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ABSTRACT

Because health promotion is a relatively new concept in Europe, a study was undertaken to gather information on informal and organized health promoting behavior and programs in Europe. The study attempts, through a review of literature, interviews, and surveys, to clarify the meaning of health promotion in both theory and practice and to identify goals, approaches, and content of health promotion programs. Section 1 of this report contains the introduction, which describes the study aims and how it was conducted, and section 2 answers the question, "Why health promotion now?" The third section discusses health promotion concepts, approaches, and people, and section 4 offers a classification of health promotion. The fifth section talks about further considerations in defining and evaluating health promotion goals, and discusses factors influencing response to health promotion and effectiveness and encouraging individual responsibility for health. Section 6 concludes the report. Appendices include: (1) survey letter; (2) "Towards an Epidemiology of Health" (position paper); and (3) summary report of a working group on concepts and principles of health promotion. There is an extensive bibliography. (JMK)

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HEALTH PROMOTION : AN OVERVIEW

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by

Robert Anderson
Institute for Social Studies in Medical Care
London

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Unit Technical Paper prepared for the
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14 South Hill Park
London NW3 2SB
United Kingdom

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"Diets then must be conditioned by age, the time of year, habit, country and constitution. They should be opposite in character to the prevailing climate, whether winter or summer. Such is the best road to health ... Fat people who want to reduce should take their exercise on an empty stomach and sit down to their food out of breath ... They should take only one meal a day, go without baths, sleep on hard beds and walk about with as little clothing as may be ... A wise man ought to realise that health is his most valuable possession."

SCHOOL OF HIPPOCRATES c. 400 B.C.
(Lloyd, 1978)

"... a man's own observation, what he finds good of, and what he finds hurt of, is the best physic to preserve health ... Examine thy customs of diet, sleep, exercise, apparel and the like; and try in any thing thou shalt judge hurtful, to discontinue it by little and little; but so as, if thou dost find any inconvenience by the change thou come back to it again: for it is hard to distinguish that which is generally held good and wholesome, from that which is good particularly, and fit for thine own body. To be free-minded and cheerfully disposed at hours of meal and of sleep and of exercise, is one of the best precepts of long lasting."

Francis Bacon, c. 1625 A.D.

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1. INTRODUCTION

1.1 Assessing priorities for health

There have always been directions and diversions marked out for travellers of the road to health and sometimes, too, guidance for the builders of that road. The directions have not invariably been agreed upon by different guides or found appropriate and acceptable to different travellers. Nevertheless, the number and variety of the signposts as well as the provision of roadside services have expanded greatly in this century - with few indications that more people are reaching the preferred destination. This apparent paradox suggests a need to reconsider the travellers, the signs, the transport, the services, the roads, and the final destination.

In the last decade, several countries have undertaken major reassessments of priorities in their health policy - most have concluded that more emphasis and effort should be directed to programmes in health promotion and disease prevention. An important stimulus and influence upon later assessments was the publication in 1974 of "A New Perspective on the Health of Canadians" by Marc Lalonde. This report aimed to assess, in a comprehensive way, influences on the development, maintenance and improvement of health. The "health field concept" was employed, which viewed health as a response to four factors: environment, lifestyle, human biology and health care organization. These factors might affect health either singly, as with environmental pollution, or together, through, for example, environmental constraints on lifestyles and individual behaviour - "Any health problem can be traced to one, or a combination of the four elements", (Lalonde, 1974, p. 33). It has been argued, however, that in practice the concept and its multifactorial approach have been diluted tending to create the impression that health is primarily dependent upon individual lifestyle choices: "these programs, in rendering health and disease a matter largely determined by individual behaviour patterns, have thrown a thick smokescreen over a host of factors which are far more influential in creating illness: poverty, sexual inequality, racism, occupational hazards and industrially created environmental pollution", (Labonté and Renfold, 1981, p. 4). It is a recurring theme of this overview that, in assessing priorities and strategies for the promotion of health, there is a need to avoid this polarisation between individuals and their social, physical or economic environments. The allocation of responsibility for health to the individual, relegating the significance of environmental variables and of persisting social inequalities in the opportunity to realize good health, gives rise to practical and ethical problems considered later in this report.

WHO: The link between the development of health and socioeconomic development was considered in the technical discussions of the Twenty-Seventh World Health Assembly, which focused on the role of psychosocial factors in health, looking at the environments of work and housing, income and education, relationships in the family, in the community and at the job, the impact of social change and urbanisation and the effects of personal life stresses on health. In responding to these influences on health, the need was recognised for a multidisciplinary health team, working at the local level, with local citizens, contributing to the development of the community. A health team, it was suggested, would be concerned not only with health facilities but with opportunities available for education, work and recreation, "since these are essential for any person's self-fulfillment and healthy adjustment" (Meyer and Sainsbury, 1975, p. 48).

The themes of community involvement, the interplay between economic and health development, intersectoral collaboration and the relevance of positive health are elaborated in subsequent WHO documents dealing with approaches to attaining the goal of health for all by the year 2000. These documents reflect a general change in focus from pathology to the ability to live an economically and socially productive life. "This means simply that the level of health of individuals and communities will permit them to exploit their potential economic energy and to derive social satisfaction from being able to realise whatever latent intellectual, cultural and spiritual talents they have." (Mahler, 1981, p. 79).

The strategy of the European Region for attaining health for all consists of three main elements: the promotion of lifestyles conducive to health, the reduction of preventable conditions, and the re-orientation of the health care system to provide care which is adequate, accessible and acceptable to all. In the promotion of lifestyles conducive to health the objectives are: "to develop an awareness among people of health problems and provide them with opportunities to make informed choices regarding their own health; to improve social and economic conditions that influence or determine choice of lifestyle and stimulate healthy behaviour; and to reduce self-imposed health risks", (Regional Strategy, WHO 1980c). A preliminary step for the attainment of these objectives has involved developing positive indicators of health to facilitate assessment of progress and the commissioning of this overview.

1.2 Aims of this study

The priorities of the Health Education Section in the Regional Office for Europe of the World Health Organization have been influenced by the analyses in the Regional Strategy, as well as by assessments of the trends and directions in health education and health promotion. There was a lack of information about the contribution of health education to health promotion activities in Europe, and little was known about the practices people engaged in to promote their health, or about the ways in which health services, voluntary organizations, government and so on supported people in their pursuit of good health. Programmes which described themselves as "health promotion" appeared to be proliferating without any clear common principles. These observations formed the background to this basic study of health promotion, for which the terms of reference were to gather information on both informal and organized health-promoting behaviour and programmes in the European region.

"Health promotion" is a relatively new concept in Europe and is not a term that is used in some countries of the Region. A major objective of the study has, therefore, been to clarify the meaning of this term in both theory and practice; and to identify the goals, approaches and content of programmes in health promotion. Given the awesome scope of this topic, it is evident that in six months no comprehensive review of health promotion was either intended or possible. Rather, the emphasis has been upon bringing to light issues which must be considered in developing awareness of, and practice in, health promotion. To this extent, the inadequacies and inconsistencies of current practice have been highlighted. A small selection of programmes has been chosen to illustrate specific issues and approaches in health promotion. Projects are not described in detail, nor is any attempt made to present a representative selection. The report aims to increase understanding of health promotion, to generate debate, and to act as a stimulus for further action and research.

1.3 Methods and sources of information

Several approaches to collecting information have been employed. The principal approach to data collection has been a review of literature in the field of health promotion, primarily that published since 1975. Unfortunately, authors in North America have written agreat many more articles on this subject than their European counterparts - in part because their experience of working with this concept is longer. It was considered appropriate at this stage to draw upon literature regardless of its country of origin, but this has created an imbalance and bias in this report towards approaches in North America, which must be acknowledged.

Attendance at conferences in Belgium and the Federal Republic of Germnany shortly after beginning the study provided a broad picture of interest in and perceptions of health promotion. Visits were made to Ireland, Denmark, the Federal Republic of Germany, Spain, the Netherlands, the Soviet Union and Switzerland, primarily to administrators, researchers and field workers in health education. After a few months, a short document with preliminary thoughts about health promotion was drafted (enclosed as Appendix I). This was sent to 108 people in Europe, selected because of their presumed interest or involvement in health promotion. Thirty-two responses to a request for views and information were received, representing at least one response from each of 19 European countries. Extracts from some of these communications are quoted in the text, but respondents are not identified by name.

Throughout the study, interviews were carried out and correspondence exchanged with a wide range of people working in the United Kingdom: in the health and education services, in social welfare, recreation services, community work, research, and voluntary organizations. It was clear from the difficulties encountered in interviews and from the response (or lack of it) to the postal communications that terms such as "health promotion" and "positive health" were not always meaningful to people like playgroup organizers, housing advisers, recreation managers and so on. Interviews with health workers in some European countries were similarly blighted, because these terms were not in current usage, even though the ideas these terms express were both found both relevant and meaningful.

The selection of literature for review and of contacts for interview was exceedingly difficult. It depended upon a notion of health promotion which developed in stages over the course of the study. There is no standard or accepted definition. It was clear from visits and meetings at the beginning of the study that "health promotion" was more often referred to rhetorically than considered in detail as a specific approach. Almost invariably, discussants - particularly health professionals - framed their responses within their own experiences with disease prevention programmes. Discussions which sought specifically to capture the meaning of "health promotion" were more remarkable for the diversity of views and meanings generated than for any consistency in the use of the concept. The rationale for describing a programme as health promotion as opposed to disease prevention or health education was seldom evident.

In many senses the technology and methodology for reviewing health promotion was not available. In carrying out the literature review a "Medline" computer search was made for publications referenced under health promotion. The articles listed included such topics as the periodic health examination, modification of risk factors for heart disease, cancer education, community nursing centres, infant feeding, aspirin and stroke, holistic health, fitness programmes and smoking, as well as those including health promotion in their title. It was not possible to detect an obvious unifying thread linking these topics, or to establish which criteria might be employed to identify a health promotion activity. It is to be expected that specific programmes in health promotion will vary between different cultures and social groups, but the range of practices described as health promotion, and the lack of agreement about whether a particular practice within one culture can or cannot be so labelled, points to a basic vagueness in the concept.

There are general difficulties with terminology in the fields of both preventiona and health promotion. Speaking at the Tenth International Conference on Health Education, Horace Ogden reported that:

> "... in the United States in the past few exciting years, there has been a proliferation of terminologies. Old familiar terms, like prevention and health education itself, are being given new connotative meanings. Relatively new terms, like health promotion are being widely used in ways that tend to blur distinctions. In fact, in some of the rhetoric now being generated, prevention, health education, and health promotion are being tossed around almost interchangeably. At the same time there are other concepts - behaviour modification, self-care, holistic health - which clearly relate to what we are doing but are certainly not coterminous with health education" (Health Education Council, 1980 p. 58).

The difficulty posed by loose terminology cannot be overemphasized.

Although a blurring of the distinction between prevention and promotion can be expected in practice, some clarity should be discernible in principle; otherwise, there would be little point in devising new terminologies.

This study cannot resolve the problems associated with uncertainties about the concept and content of health promotion, but it is intended to make explicit some of the issues which must be tackled for development in this field. The introduction continues with a brief outline of some major initiatives in health promotion. This is followed by a review of some factors which have led to the development of new policies for the improvement of health. The concept of health promotion is discussed in some detail, specifically to distinguish it from disease prevention, and certain approaches are identified. In particular, the contributions of different sectors in government, work and the community are assessed, as well as individual health behaviour. A classification of health promotion practices and a typology of health promotion activities is presented, with selected examples from Europe. Finally, reference is made to several lessons which should be drawn from experiences in disease prevention; and some concluding comments are made.

1.4 Major initiatives in health promotion

Outside Europe

In Canada, the Health Promotion Directorate was established in July 1978, incorporating the former Non-medical Use of Drugs Directorate, the Focal Point on Lifestyles, the Nutrition Education Advisory Services Unit, and the promotional component of the Family Planning Unit. The overall objective of the new Directorate is "to increase the capacity of Canadians to maintain and enhance their level of health", primarily by promoting lifestyles such that individual behaviour is conducive to good health and the avoidance of unnecessary risks. This central unit is a resource for offices in the provinces, from which community programmes are organised. In Thunder Bay, Ontario, for example, a fitness campaign has begun, "designed to provide opportunities for lifestyle enhancement and create a supportive cultural and physical environment for individual well being" (Leister and Welch, 1980).

Approaches to health promotion are more developed in North America than elsewhere, and a similar picture of rapidly expanding activities in the field can be described for the United States. The author and Dr Kickbusch, Regional Officer in Health Education, visited North America in April 1982. A report of this "study tour" in available from the European Office of WHO. The American Office of Health Promotion has suggested a definition of health promotion as: "any combination of health education and related organizational, political and economic interventions

designed to facilitate behavioural and environmental adaptations that will improve or protect health" (Office of Health Promotion, 1980). Within the Department of Health, the Office of Health Promotion is responsible for co-ordinating all activities related to health information, health education, physical fitness, sports medicine, preventive health services and education in the appropriate use of health care. In 1980, for the first time, the annual report on "Health" in the United States included a "Prevention Profile" documenting the state of the art in disease prevention and health promotion. In future, a report on progress in attaining prevention targets in 15 areas - high blood pressure control, family planning, pregnancy and infant health, immunisation, sexually transmitted diseases, toxic agent control, occupational safety and health, accident prevention and injury control, dental health, surveillance and control of infectious diseases, smoking, misuse of alcohol and drugs, nutrition, physical fitness and exercise, stress and violent behaviour - must be presented to Congress every three years. There appear to have been equally rapid developments in holistic health care (Berliner and Salmon, 1980) and in the purchase of goods claimed by individuals and industry to be health-promoting (Allen, 1980). Altogether, a new health (and probably disease) consciousness has invaded parts of the American culture, evidenced by the proliferation of health magazines, availability of health foods, the running explosion, and concentration on health by the media; "the concern with personal health has become a national pre-occupation" (Crawford, 1980 p. 365).

The growing interest in health promotion, particularly in changing individual lifestyles and behaviour (and less so the environmental and other elements in the "health field") is not limited to North America. It has been suggested that "health promotion ... could become the main item in the armamentarium of Australian health authorities in the 1980's" (Howells, 1980 p. 18).

Europe

It is within the last five years or so that reference to health promotion in administrative titles, publications, media and conference themes has clearly increased. This has been accompanied by, or may reflect, a growing concern to highlight activities which promote health in addition to those activities for the management of health problems.

It is rare to find the term health promotion used in isolation - it is generally to in the context of disease prevention or health education, e.g., departmental titles include "Health Promotion and Health Education" (Belgium), "Health Promotion and Environmental Health" (Spain); new priorities for the attention of health authorities in England and Wales include strategies for "health promotion and preventive medicine" (DHSS, 1981a). The elements of this last-mentioned strategy, like the responsibilities of the Health Promotion Offices in North America are diverse - smoking, genetic counselling, ante-natal care, screening for disabilities in children, health surveillance of children, immunisation against infectious diseases, reducing risk factors for heart disease and strokes, health education, accidents at home and on the road, fluoridization, - and it is not immediately clear which elements are specifically health promotion.

The momentum for health promotion is increasing. In September 1981, the First Conference of European Ministers responsible for the Public Health took place, on the theme of "a European approach to health promotion". The Conference concluded that prevention should be assigned a wider and more important role in health policy and that health policy should itself be "comprehensive and integrated and pivot on the promotion of health" (Final Text, p. 1). The publishing houses and media have turned their attention to health. Books directed at the public as guides to looking after yourself, to good health, to improving your life or potential for living command their own distinct sections in bookshops. Van Parijs (1980) notes that between 1978 and 1980, the Centre for Health Promotion and Education in Brussels collected more than 100 books in Dutch and French published in these years on popular health subjects. The same is true in the United Kingdom, where peak-hour television has programmes on relaxation and stress management, diet and exercise. The Times Newspapers Group introduced a new "Health Supplement" in autumn 1981 (subsequently moved to the Pergamon Press); this "will be interested in the well-being of the population and not just in the treatment of disease. It will take note of changes in the shape and behaviour of society and in individual lifestyles ... as they affect planning for health. The possibilities of the less conventional approaches to good health will be explored. The implications for health policy of changes in the economy, in industry, housing, education and social welfare will be considered" (Times Health Supplement, Press Release, 4 June 1981).

These introductory observations are intended only to illustrate the growing interest in health promotion and the increased use of this term. The health promotion concept has been developed into a powerful tool employed by groups involved in the improvement of health. The diverse activities collected under the umbrella of health promotion were being carried out long before the Lalonde Report, in some cases using the title "health promotion" (e.g. by the Swedish

Sports Federation and others: "Food and Physical Activity", 1970). In other countries objectives similar to those in health promotion have guided activities within the health system, e.g., in the Soviet Union, prophylactic measures have been organized to "contribute to the work of transforming the human environment, improving the quality of life in order to guarantee people satisfying and joyous labour, good rest and recreation, strengthen the peoples' health and ensure them a long active life. Prophylaxis forms an integral part of the measures to improve well-being of the people, raise their material and cultural standards and promote the balanced and full development of the physical and intellectual powers" (Lisitsin and Batygin, 1978 p. 91). Finally, a major impetus for the improvement of health derives from the activities of social, community, voluntary and workers' groups, who describe their activities in terms other than "health promotion".

There are many signs that a significant reappraisal of directions in health policy is underway, in which a comprehensive assessment of factors influencing health, and an appreciation of the linkages between people and their environment, particularly as this affects their ability to realise good health, are paramount. As a recent major review of social inequalities in health concluded: "We see the time as now opportune for a major step forward in health and prevention" (DHSS 1980, p. 292).

2. Why health promotion now?

2.1 Positive health

Like so many other concepts in this field, the meaning of positive health is elusive, though, in general, it is employed to draw attention to the possibilities of good health beyond an asymptomatic state. As control of diseases has improved, so interest has grown in the positive aspects of health (Breslow, 1972). As working conditions and economic resources improve, so people have more time and opportunity to attend to the quality of their lives, and especially to enhance feelings of personal well-being. It has been suggested that health services should re-focus their activities to move people towards health, not only away from disease (Carter, 1980); a sentiment which is shared in statements about the potential contribution of health services to improve well-being and quality of life (DHSS, 1977; Morris, 1980). However, the interest of the medical profession in promoting positive health is not unquestioned (Menninger, 1976), and Dixon (1978) concluded that "The interest that has grown up in recent years in the positive fostering of health has come largely from the environmentalists and advocates of alternative lifestyles rather than from doctors or governments" (p. 166). In general, the movement for promoting health, in its broad sense, has taken a social rather than a medical form, without the active encouragement of governments. Nevertheless the value of good health is not lost on governments: "Good health is the bedrock on which social progress is built. A nation of healthy people can do things that make life worthwhile, and as the level of health increases so does the potential for happiness" (Lalonde, 1974, p. 5).

Concepts of positive health are bound up with judgements about preferred quality of life and the potential of the human condition. They may refer to notions of self-fulfillment and self-realisation, energy for living and creativity, growth and development. Like health, there are physical, social and mental components, and some conceptions of positive health may reflect a kind of super-health along these dimensions. This is akin to the positive or optimal health which it has been suggested was previously relevant to natural selection: "It is worth emphasising that one of the most significant influences of civilisation on the biology of man has been the removal of optimal health as a prerequisite for individual survival and reproductive success. In the evolutionary environment, survival and reproductive success were dependent on superb physical fitness, acuity of vision and hearing, absence of debilitating or painful illness, mental alertness, a good memory and a state of mind which permitted, when necessary, concentration, patience and a willingness to co-operate with others. None of these attributes is necessary for the individual's survival and reproduction in the protective environment of modern society, although, clearly, many of them are important in relation to life enjoyment." (Boyden, 1973). Some evidence of the relevance of notions of positive health to the lay public is presented in Appendix II.

2.2 Ideology and consumerism

The growing interest in positive health is intimately tied to rising public expectations of, and demand for, better health and improved quality of life. But there is a spreading conviction that these expectations have not been, and will not be, met by medical care or other institutionalised services. On the contrary, the potential for developing health is seen to lie to a considerable extent within the power and capacity of the public. The release of this

potential depends upon the control that people have over their own lives and the forces that mould those lives. In health matters this means that the public must demand and receive the information with which to develop a more critical awareness of the impact of different goods, services, personal activities and environmental conditions on health. Subsequently, effective consumer choice or behaviour implies the ability to use the information, and the availability of selected services or other resources. In the market place for health goods and services the consumer may require both assistance and protection (Cornacchia, 1976).

There is evidence of increasing consumer participation in the planning and delivery of health care services (Greve, 1980), of increasing numbers of community and interest groups with a specific focus on health (National Council for Voluntary Organisations, 1982), and of selection of alternative health services, which give a higher priority to the development of health and wellness, e.g. the holistic health care movement: "The positive health orientation of holistic therapy has two separate components. The first is the perception of health as a value in and of itself; the second is the notion of health as a praxis - the active participation of the individual in the ongoing maintenance of his/her own health" (Berliner and Salmon, 1980, p.142). However, the dangers and inadequacies of approaches which focus exclusively on the individual, neglecting both the social and economic context in which people act, and the direct effects on health of environmental conditions beyond personal control (see e.g. Faden and Faden, 1978) point to the need for broadly-based approaches to improving health. (This issue will be discussed more fully in a later section.)

2.3 Limitations of health education

There is no doubt about the major and essential contribution that health education can make to the improvement of health. As a professional activity one of its principle goals is to promote the harmonious development of the human person in all respects - physical, mental and social (International Union of Health Education, Constitution). However, there remain uncertainties about its role, scope and effectiveness.

The term health education has a number of meanings, depending in part upon the level of generality at which definitions and statements of objectives are located. Thus, health education "may be defined as the sum total of all influences that collectively determine knowledge, belief and behaviour related to the promotion, maintenance and restoration of health in individuals and communities" (Horner, 1980). This all-inclusive definition recognises that many influences determine knowledge, beliefs and behaviour related to health. It does not direct us to formal or planned activities and therefore, health education influences must be traced back from their outcome. There is no unanimity about the objectives of health education. Typically the goal is to improve health by changing behaviour in a pre-determined direction. Hochbaum (1971) observed that ".. the task of health education is to equip people intellectually and emotionally to make sound decisions on matters affecting their health safety and welfare .. it tries not only to equip people with the means for making sound decisions, it also tries to influence the outcome of such decisions ... its specific goal is to improve people's health behaviour". An alternative perspective leaves the public to analyse issues openly, increasing awareness of the total range of options available and leaving people free to decide for themselves how to behave. Greenberg (1978), for example, proposes that "the objectives of health education not be decreasing the incidence of smoking, drug abuse or any other health-related behaviour. Rather the objectives should be to improve self-esteem, decrease alienation ... learn health knowledge and skills and so on" (p. 21).

It is commonly suggested that, in following the "medical model" in its activities, health education focuses narrowly upon the individual, both as the target of its programmes, and as the object of change in behaviour. Such limited horizons therefore, fail to address groups with important influences on health (e.g., health professionals, industrialists, government) and neglect the social conditions in which personal lifestyles choices are made (see e.g., Brown and Margo, 1978). In response it has been contended that the professional responsibility of health educators is to focus upon individual rather than social action (Van Parijs, 1980), while another perspective suggests that, as part of health promotion, health education "is directed as much at groups, organizations and communities as at individuals and it is concerned as much with environmental, economic and social changes influenced by behaviour as with lifestyle habits and preferences" (Green, 1980. p. 38). In this respect the behaviour change of concern to health education is not only related to lifestyle but also to collective behaviour (of, e.g., leaders in industry and administration) and social action. In practice, a proportion of health education groups appear to work actively with voluntary organizations and representatives of other sectors such as health care, education, agriculture, sport and communications, promoting change in legislation, administrative and fiscal policies (e.g. Player, 1981). It appears that in some countries health education is already integrated into a broader health promotion complex, with

political, organizational and economic approaches. A health educator from Czechoslovakia reported that "it is just the complex approach which can really cause a change in human behaviour and will also result in effective health promotion. Therefore, health education should be, as far as possible, an integral part of such complex programmes because only in this way can health education be really efficacious." Of course a variety of political, financial and practical considerations limit the extent to which health educators are actually in a position to take account of the relevant social and economic factors.

This comment opens up the vexed issue of effectiveness in health education, and the conditions in which the goals of health education can be attained. This has been the subject of three recent thorough reviews in the U.K. alone (Pell and Bellington, 1979; Gatherer et al., 1979; Tones, 1977) and cannot be the subject of an adequate commentary here. The evaluation of health education programmes is prone to many difficulties (Green, 1977), so that it has been frequently neglected (Tones, 1977) or inappropriately carried out (Cohen and Cohen, 1978). On the whole, it appears that existing methods of encouraging people to lead lives considered more healthy have achieved only modest success (Royal Commission, 1979; Anderson et al., 1980) and there is no evidence of any direct links between knowledge, attitudes and behaviour.

Programmes which employ changes in legislation or taxes and those which involve the local community in political action to change social conditions seem more likely to succeed: "For most health problems a combination of approaches using all methods to change lifestyle and appropriate use of medical care will be necessary ... for some health problems we may decide that they must be endured in order to support values more important than health" (Haggerty, 1977, p.276). It is not self-evident that good health will always be valued above other rewards or satisfactions, though clearly its relative value and the qualities which are valued more or less, will depend upon the meaning of health in any particular context. In a study of quality of life in Britain, respondents were asked "What does quality of life mean to you?". Health was referred to by 10% of the population, ranking seventh behind reference to other qualities such as personal beliefs and religion (11%), money (18%), and family life and marriage (23%) (Hall, 1976). Lifestyles conducive to health may not be the most favoured, when the social and economic conditions are not supportive. It is not so outrageous to suggest that, in these circumstances, if one adopted an alternative "healthy" lifestyle, "this new way of living (which is antithetical to the popular mode) would inevitably result in increased job frustrations, insecurity, financial hardships and a whole new set of stresses" (Cohen and Cohen, 1978, p.719).

2.4 Lifestyles and Health

"A 142-year-old man is alive and well in a remote province of east central China, the Xinhua news agency said yesterday. Wu Yunging said he had prepared his own coffin three times over the years - the first two had rotted with age and he had used the third to build floorboards for his room. He claimed that the secret of long life was moderation, diligence, physical exercise and optimism" (Guardian 1/9/1980, p. 4). Notions about the ingredients of the elixir for a long life typically make reference to moderation in all things and the adoption of a positive outlook of life, relegating to significance the background elements of the physical and social environment. Specifically, explanations have concentrated upon the relationship between certain personal activities - eating, drinking, exercising, smoking - and longevity. The results of the Alameda County study linking personal health habits to life expectancy and health states have been widely reported and used as a basis for health promotion programmes. Early results of the study following 7000 adults for five and a half years showed an association of health habits with physical health status, which was independent of age, sex and income level (Belloc and Breslow, 1972). The physical health status of people following all seven good health practices - eating three meals a day at regular times instead of snacks; eating breakfast every day; taking regular moderate physical exercise; sleeping seven or eight hours at night; not smoking; maintaining proper weight; and consuming alcohol, if at all, only in moderation - was the same as that of people thirty years younger who followed few or none of these practices (Belloc and Breslow, 1972). In a follow-up study in 1974, which obtained data from 78% of presumed survivors, it was reported that "Men following seven practices had a (age-adjusted) mortality rate only 43% that of all men in the survey, and only 28% that of men following zero to three practices" (Breslow and Enstrom, 1980, p. 479). The data were highly supportive of a causal link from habits to mortality, rather than suggesting that habits were a response to pre-existing morbidity. The association was not attributable to only one cause of death or to only one major group of diseases. Considering these practices as predictors of future health, an analysis by Wiley and Camacho (1980) found no clear influence of eating breakfast, or meals at regular times; suggested benefits of moderate alcohol consumption and leisure-time physical activity and pointed to risks associated with managing less than seven hours sleep at night, and with being extremely (30% or more) overweight. Some of these practices differed between social classes, "but effects of health practices on future health cannot be accounted for by variation in income or education, nor can

the importance of socioeconomic status to health be explained by class differences in health practices" (p.20). Both social class and health habits contribute to future health.

The influence of socioeconomic factors on health status, particularly as indicated by mortality and morbidity data, remains as persuasive as ever, and a recent review in the United Kingdom found no evidence of a narrowing in the differences by mortality and morbidity between social classes (DHSS, 1980). In a review of mental health promotion and mental illness prevention, Eisenberg (1981) was confronted throughout by evidence of differences by social group: "Being poor, black, employed in certain industries, unemployed, or elderly and dependent, to name a few, is to be subject, not to unique diseases but to increased rates of incidence and prevalence for most diseases and to higher mortality for many" (p.15). Clearly, the reduction of inequalities in health will be central in any strategy to promote health in society, but the measures taken must be grounded in an understanding of the ways in which social class factors influence health, as well as in knowledge of the attitudes and priorities of different social groups. Socioeconomic differences in health reflect inequalities in the distribution of economic, social and political resources; access to, and availability of, services and goods; environmental conditions at work and home; and differences in the organization of family life, as well as the mode and style of living. The various factors and their complex interrelationships point to the inadequacy of exclusive concentration on lifestyles and health, particularly as the concept of lifestyles is currently presented. The definition of lifestyle is ambiguous and varied (Taylor and Ford, 1981), but it is frequently used in a limited sense, referring to personal behaviours which appear to be risk factors for specific diseases or health problems, e.g., eating, smoking and exercising in their relation to the incidence of cardiovascular diseases; drinking in relation to violence, accidents, liver disease. Such formulations have generally neglected significant elements such as the organization of family life (Pratt, 1976), social participation and social networks (Berkman and Syme, 1979), employment status (Brenner, 1979), the home and work environments, personality and social values.

In explaining differences in health, the contribution of lifestyles appears highly significant, so much so that it has become the focus of many programmes in health education aimed at reducing the incidence of diseases through individual behaviour change. This concentration on personal behaviour should be assessed from a perspective which considers the importance of the social, economic and physical environment, both in its direct impact upon health and as a factor influencing individual behaviour. The health action model (Tones, 1979), which analyses factors involved in making health decisions, involves specific consideration of the influence of societal norms in general and of significant people in particular; the role of knowledge, belief and motivation (or preferences) leading to a behavioural intention; appropriate environment and conditions as well as relevant skills and knowledge to translate an intention into a decision. These intervening factors between stimulus and decision can in turn be incorporated as dependent variables in multifactorial explanatory models, as can, too, the link between decision and action. This discussion of lifestyles has been framed largely in terms of diseases, morbidity and mortality, as indeed are most commentaries on lifestyles and health. The implications of realigning our sights to focus on health, and the new criteria for selection of significant lifestyle elements, knowledge, skills and environments which such a realignment would dictate are discussed in Appendix II.

2.5 Medical care and health

The purpose of medical services is to improve the general health of the population, as well as supporting or restoring those in ill-health. The Royal Commission on the British Health Service stated that the first objective of the National Health Service should be to "encourage and assist individuals to remain healthy". However, assessment of the contribution of medical services to health is usually couched in terms of mortality and morbidity, or reduction of ill-health. This may not adequately indicate or represent the outcome of work in the medical services, but it is the perspective in which most discussion is grounded. The relationship between medical care and health has become the subject of increasingly critical attention, concerning, for example, the role of medicine in producing and reducing ill-health, the costs and effectiveness of medical care.

"According to the Great Equation, medical care equals health. But the Great Equation is wrong. More available medical care does not equal better health. The best estimates are that the medical system (doctors, drugs, hospitals) affects about 10 per cent of the usual indices for measuring health: whether you live at all (infant mortality), how well you live (days of sickness), how long you live (adult mortality)." (Wildavsky 1977, p.105). Arguments about the relevance of medical measures to health improvements in the previous 100 years are well known. The work of McKeown and colleagues, in particular, shows that the main influences on the nineteenth century decline in mortality were: rising standards of living; improved diet

associated with changes in agricultural production and distribution of food supplies as well as greater individual purchasing power; efficient control of sanitation; and improvements in housing, living conditions and population density. Clinical measures, including immunization contributed little, and appear in this century to have played a relatively minor role in the falling mortality due to infectious diseases. (McKeown, 1976; McKeown et al, 1975), with some obvious exceptions, e.g. smallpox vaccination. In their evidence to the Royal Commission on the NHS, the Health Education Council concluded that the "three main components of successful health promotion over the last 100 years were achieved by regulatory procedures affecting the environment, specific programmes addressed to pregnant women, infants and school children, and the general improvement in the level of nutrition". (Royal Commission on the NHS, 1979 p 41). In summary then, changes in the physical, social and economic environment, as distinct from individual behaviour in isolation, appear to have been more relevant to reductions in morbidity and mortality than developments in medical care.

Contemporary analyses suggest that mortality rates are influenced much more clearly by differences in income, education, housing and environmental quality than by health services, an argument summarized by Dowie (1975) as "Health is produced by households, not by doctors and hospitals." (p. 622). Indeed, the relationship between health outcomes (such as mortality, morbidity and disability) and sociodemographic factors is so pervasive that new health indices are being designed to reflect more sensitively variations in medical care (e.g. Martini et al, 1977).

Expenditure on health services has increased vastly in the last 30 years, absorbing now between 5 and 10 per cent of the Gross National Product in Western European countries. The costs have increased most clearly in the hospital sector, where developments have been characterised by high technology and specialization. More money, more technology and more specialists have not achieved equivalent reductions in mortality, while their impact on the quality of life awaits more adequate assessment. Differences between countries in spending on health services or number of doctors do not appear to be matched by health outcomes (Abel-Smith, 1981; Cochrane et al, 1978). Spending on medical services is, it is argued, increasingly subject to the law of diminishing returns, and the product of health services appears to be of increasingly doubtful social relevance (WHO, 1978a). Awareness of these circumstances has led to some disillusionment with modern medicine, and a reassessment, not only of medical care, but also of alternative approaches to the improvement of health.

Health policy makers have turned to prevention and modification of individual behaviour as key themes in response to the problems outlined. (See e.g. Davis, 1979). The report of a committee on health priorities in Denmark noted that "In recent years there has been a growing interest in prevention through an effort within the health sector as well as within other sectors. This trend appears at the same time as scarce resources and certain doubts as to the effect of 'marginal investments' in the treatment sector have begun to make themselves felt in this part of the health service" (Ministry of the Interior, 1981, p. 33/34). A government inquiry into preventive medicine was undertaken in the United Kingdom at the end of 1975 "in response to.... concern at the growing cost of the National Health Service and the high and increasing share of the total NHS expenditure which was being devoted to hospital services, most of which are curative services, compared with the relatively small sums spent on prevention" (DHSS 1977, p. 1). The focus for preventive action, and consequently for the improvement of health and the quality of life was grounded in "seeking to modify attitudes and behaviour in relation to health" (p. 6), and in encouraging individual responsibility for health by promoting a greater flow of reliable information and advice. This emphasis reflects the sentiments of many other observers, that future improvements in health are more likely to come from changes in lifestyles than from increased spending on medical care (e.g. Aring, 1978; Saward and Sorensen, 1978). While, in the United Kingdom, the promotion of healthy lifestyles was identified as the main new direction for improving health, it was, in principle, only part of a package which included efforts to improve living conditions, reduce health hazards in the environment and provide adequate and accessible goods and services (DHSS, 1977). It was not suggested that improving health was the exclusive concern of medical care. The DHSS document (1977) refers to the essential tasks facing the education, social and community services, mass media, industry and government, as well as parents and families.

The links between medicine and health go beyond the traditional conditions and diseases reported in mortality and morbidity data, to those aspects of personal and social life which have increasingly become the domain of medical intervention and expertise, e.g. family relations, child development, sexual behaviour, and many forms of deviance. The medicalization of everyday life has created new difficulties, as well as opportunities, for the medical profession. Interest in dealing with some of life's problems is balanced by professional concerns about the appropriateness of consultations for other problems (Cartwright and Anderson, 1981) and questions about the reasonableness of certain expectations: "Many within the profession believe that both

the expectations and anxieties (of the public) are the result of a definition of health that has become much too broad and that certain limits on the responsibility to society of the medical profession need to be established." (Knowles, 1977, p. 4/5). The definition and concept of health applied in programmes of health promotion may not be coterminous with the current priorities, expertise or interests of medicine. Thus, in the promotion of a "socially and economically productive life" attempts to diagnose and cure diseases may be only marginally important beside non-medical efforts to improve social and economic life. The relevance of different strategies and resources to the improvement of health will depend upon the definition of health employed. Some concepts of health and our current understanding of its origin and mainterance are considered in Appendix II.

3. Health promotion

3.1 Concepts:

How does the previous commentary on motivation for alternative directions in health improvement and on the meaning of health relate to current concepts and approaches in health promotion? It must first be reiterated that the concept of health promotion is vague, but powerful, evidenced by its incorporation into the titles of government institutions and policy documents. The words "health promotion"conjure up impressions of a positive, dynamic concept, which is one reason why they are so politically attractive and rhetorically useful. It was evident during the survey that health promotion was difficult to identify or specify as a concept which stood on its own, independent of links to health education, disease prevention or environmental protection. This was particularly obvious in interviews; it is only from the postal survey of responses to a short background paper (Appendix I) that views which distinguish health promotion from other existing activities have arisen. Finally, it is important to note that people working in medicine and health services are those most likely to have some concept of health promotion and to consider the concept relevant to their work. Most of the literature which discusses health promotion is written by people involved in health education, public health and primary health care. This literature forms the basis of the present review, although, of course, the activities of health services may not contribute most to the promotion of health. Contacts with people involved in the promotion of sports, the organization of cultural events, the provision of nursery facilities, and the design of homes and work-places, and others outside the health institutions were not generally productive in terms of clarifying health promotion concepts. These pople did not view their work primarily in terms of health promotion, though they recognized that their activities had consequences for health.

In the formal literature there are a number of concepts and definitions which appear to overlap. In particular, some concepts of primary prevention and health education seem very close to other statements about health promotion. This reflects in part the incorporation of methods and approaches into definitions of health promotion, and in part some confusion about the goals of health promotion and the extent to which it is a separate, complementary or identical activity to disease prevention. This confusion is illustrated in statements that, on the one hand, "preventive medicine comprises prevention of diseases, care, and the promotion and maintenance of health" (WHO, 1978, p. 4), and on the other, "Health promotion is the effort designed to reduce unhealthy behaviour, improve preventive services, and create a better social and physical environment" (McAlister et al., 1981). Disease prevention and health promotion are frequently used synonymously as umbrella terms for activities which are carried out by health services, but which are not cure, care or rehabilitation.

Some definitions of health promotion are almost limited to disease prevention, oriented towards reduction of risk factors for specific disease or, more positively, towards "the enhancement of host factors that contribute to resistance to disease" (Eisenberg 1981, p.5). Health promotion programmes have been set up "dedicated to the prevention of certain chronic diseases" (Jacobsen and Pellegrino, 1977), and the label health promotion has been attached to programmes aimed at the reduction, in particular, of cardiovascular disease (e.g. the North Karelia Project; WHO's 'Health Promotion in Youth' activity). The focus of these disease prevention programmes is on changing lifestyles and behaviour related to these diseases, e.g. diet, exercise, stress, smoking - areas of traditional interest to health education and health promotion. Therefore, specific measures to prevent disease and disability may contribute likewise to the promotion of health and well-being. The question is whether a distinction can be made between the goals and approaches of these two activities - and when such a distinction would be relevant to practice.

"Exercises in logic drive some people bananas which helps to explain why discussions of whether one is really doing promotion or prevention also drives some people bananas and causes just about everyone to go round in circles. There is no way to separate the two, they are simply different but equivalent ways of describing the same thing." (Low undated p.4). The author went on to discuss the implications of using the term health promotion. Essentially, he points out that it is attractive with positive connotations, and that it directs our attention away from the specificity of diseases to a broader perspective. Room (1981), who attributes the trend to health promotion in part to the increasing importance of chronic diseases and the etiological significance of general lifestyle characteristics, similarly identifies differences in approach, rather than objective. He analyses these differences in a series of dichotomies: optimistic - small-minded; positive - negative; behaviour - microbiology; people - machines. These dichotomies are heuristically useful, but the author recognizes that they "confuse together dimensions that can and do operate independently - professionalization versus self-help, sophisticated technology versus simple tools, a holistic versus a targeted approach, and incentive and encouragement versus deterrence and dissuasion" (p. 27). Even with its positive rhetoric, Room (1981) argues that health promotion has been concerned mainly with stopping rather than starting behaviours, but in conceptual terms it seems useful to distinguish the notions of limiting as opposed to creating demand and opportunities appear useful. How health promotion might create opportunity and demand for health or healthier choices is discussed shortly in a consideration of approaches.

It has been suggested by McPheeters (1976) that while prevention is targeted towards persons under some specific stress or risk, promotion activities are directed widely at people in normal situations of growth and development (which will always involve some level of risk). Again this makes a useful point of distinction between the two approaches, though it is clear that some strategies labelled as prevention are directed at entire communities (e.g. Rose, 1981, the community cardiovascular disease prevention programmes in California (Meyer et al., 1980) and North Karelia (Puska et al., 1981), and the form of primary prevention conducted by the Federal Centre for Health Education in West Germany). Equally, there is no reason why priority health promotion programmes might not be directed at specific groups with greater potential for benefit, e.g. to those disadvantaged with fewer opportunities at present for growth and development. A developmental perspective aimed at fostering healthy growth and development has also been incorporated into a view of primary prevention (Kagey et al, 1981). Altogether, the conceptual field is unclear, with little in the way of philosophical consensus to guide health promotion. Higgins and colleagues (1980), in a survey of health promotion activities, defined them as "those intended to enhance the existing state of health, and prevention activities were those intended to obviate or avoid disease" (p. 154). Although it is appealing to see health promotion defined in terms of goals rather than approaches, it is difficult to see how the distinction can be made consistently, while to discuss health promotion as improving health leaves open the identification of that which constitutes health. Relatively few authors make their concept of health promotion explicit; most who attempt a definition fail to make a clean break from concern with diseases; and no-one seems to have dealt with the concept in an entirely positive sense beyond adaptation and adjustment towards liberation of creative energies for the development of a fulfilling and constructive life.

The definition of health promotion employed in the postal survey was that of the United States Office for Health Promotion (1980): "... any combination of health education and related organizational, political and economic intervention designed to faciitate behavioural and environmental adaptations that will improve or protect health". In general, there was a good deal of support for this definition, particularly because it was wide-ranging and because it included changes in both the environment and the individual. There was also support for a definition which emphasized health promotion as the specific aim of the intervention, i.e. limited the identification of health promotion activities to those designed to improve health. (It was noted without concern that this defined health promotion by intention, not effect). However, there were differences of opinion about whether individuals could be included as intervening to promote their own health, or whether health promotion should be limited to the activities of external agents A Swedish respondent suggested the label "healthy practices" be designated for activities of the individual. However, other respondents made a point of including individual activities, and there would be some difficulty in excluding those forms of behaviour that individuals engage in which are of a social, political or group nature, aimed at changing their environment or living conditions.

It was suggested by several respondents that specifying interventions such as health education, political and economic activity was limiting. Why should cultural, genetic, social or other intervention be excluded? Health promotion "embraces the whole of measures which allow every individual a level of health compatible with the full development of his capacities and capabilities" (Health educator, Portugal). If individual and informal, as well as organized and

external, intervention of all forms designed to improve health are included, then the American definition is too limited. Two points appear unclear in the definition. Firstly, the concept of adaptation; whether this implies response to external change and return to equilibrium, or could involve more active adjustment of the environment to facilitate the realization of individual aspirations and ambitions (in an almost identical definition, Green, 1980, discusses "changes conducive to health" as opposed to "adaptations that will improve or protect health"). Secondly, the question of whether disease prevention is encompassed by this definition. In the background paper for the postal survey (Appendix I), the following was therefore made explicit: "... I have decided to exclude from consideration programmes which have as their main purpose the reduction of risk factors for particular health problems. Similarly, I am placing illness management and rehabilitation activities outside my concept of health promotion because they are prompted by the need to manage an existing problem." This statement received a number of comments, which were equally divided between those who felt a concentrated or more limited focus appropriate and those who referred to the important role played by risk-factor reduction in improving health and in making politicians and communities aware of relevant general health issues. One respondent involved in the the North Karelia Programme suggested that the exclusion of risk factor reduction programmes "may be wise with a limited health problem, but in the case of prevention of the major chronic public health problems (cardiovascular diseases and cancer), promotion of health and prevention of the diseases are so closely linked that they simply cannot be separated. We have a great number of programmes in Europe, which aim at smoking cessation, adoption of prudent diet, loss of overweight and increase in physical activity, which shall result in promotion of health and prevention of severe diseases." The potential for, and appropriateness of, a definition of health promotion which excludes disease prevention needs more criticial assessment.

The most meaningful definition of health promotion is likely to be framed in terms of the aims of the activity, rather than the means employed to achieve unspecified ends (even if these means, or the health promotion approach, are themselves distinctive). This will require much more precise identification of the goals of health promotion. In this task, health promotion faces similar problems of philosophy to those (still being resolved ?) in health education. Are the goals to increase awareness of factors influencing health and to extend opportunities for people to make choices which lead to health, or is there a more specific goal to promote certain behaviours and ways of living? Will achievements be measured in terms of increased control over personal destinies or in terms of compliance with lifestyles conducive to health? Will a successful health promotion programme reduce the incidence of health problems, increase levels of life satisfaction, or both?

Taking Canada as an example (because the documentation is good), there may be some move to locate the goal of health promotion in terms of health rather than disease, at least in principle. Labonté and Penfold (1981) quote a Canadian Public Health Association statement from 1974, which defined the goal of health promotion as "preventing physical and mental ill-health through the promotion of better personal habits and the elimination of self-imposed health risks". In 1979, the Canadian Health Promotion Directorate expressed its purpose as being "to increase behaviour which contributes to personal health and well-being, and to reduce behaviour which exposes individuals to risk of disease or accident" (HPD, 1979, p.4). This was based on "a comprehensive view which gives equal value to a more protective principle of freedom from illness, and a more active principle of well-being. In addition, HPD views health as an integral aspect of human development, which affects and is affected by such other factors as productive employment, a sense of social purpose and values, and individual and collective autonomy. It is recognized that many of these factors are outside the scope of a health programme. Nevertheless, they have an important impact on health status, and serve to set limits to what can be independently accomplished through intervention in the health field." This related but separate question of the scope of health promotion will be considered when discussing a typology for health promotion. However, there is the obvious difficulty that the scope of health promotion may seem unlimited; if we consider positive mental health, it is difficult not to conclude that all domains of living have some potential to contribute to its development. It is then a matter of having some basis (e.g. knowledge of the epidemiology of health) or method for establishing priorities.

3.2 Approaches

There are three basic questions which must be answered to develop methods for the promotion of health: what is to be done and for whom; how is it to be accomplished; by whom are health promotion activities to be carried out? The answer to these questions will be conditional upon our knowledge of factors influencing health and the dissemination of this knowledge; the resources available for health promotion; and the existence of a social and political environment conducive to health promotion.

Our inadequate knowledge of factors influencing health and the failure to disseminate effectively that information which is available serves both to inhibit and misdirect the development of health promotion (Labonté and Penfold, 1981). Even when knowledge exists about factors influencing health, there may be considerable disagreement about the measures to be taken for its improvement. Referring to the prevention of psychosocial disorders in childhood, Rutter (1978) has concluded that: "... there is a mass of evidence on the various factors that predispose children to psychiatric, social and educational problems. Moreover, our indecisiveness on the course of preventive action to take does not reflect major disagreements about children's needs or about principles of child rearing.... The difficulty lies in knowing how to bring about the desired results. It is all very well to agree that children need love, security, stimulating experiences, responsibility, encouragement and so forth. They do, but how do you ensure that they get them?" (p. 105). In the absence of clearly specified goals for health promotion and considering the deficits in knowledge about factors infuencing the (more positive) development and enhancement of health, questions about approaches must be dealt with in a general, rather than comprehensive, way.

Education and information about health and lifestyle, health and environment, health and social policy (Draper et al. 1980) are necessary for developing an awareness of health, which will enable people to make personal and community decisions for health and social policy (Brown & Margo, 1978; Labonté & Penfold, 1981). The Director-General of WHO has suggested that nothing "can truly be changed when it comes to overeating, overdrinking, abuse of drugs, overstress and alienation, if we do not give power to the people to understand their own predicament, and then make conscious decisions about where they want to go" (Agarvil, 1980, p. 207). Of course, the type and extensiveness of the information available will depend upon the knowledge, beliefs and motivation of those providing this information. If it is considered appropriate, for example, to persuade people to adopt particular behaviour, then the information made available is likely to reflect this inclination. However, there appears to be a growing realization that relevant information must be defined in terms of local conditions, culture and resources (Anderson et al. 1980). This creates the potential for individuals and communities to identify local needs, priorities and strategies for action (WHO, 1980c; Gibson, 1979). Health promotion needs the support of an informed public (Terris, 1977) and efforts to link the improvement of health to general improvements in the quality of life in communities will be most effective if the local community is involved at the initiation of the planning process (Abel-Smith and Leiserson, 1978). The same principle of community involvement and support appears essential for the maintenance of changes conducive to health (McAlister et al, 1981; Allen, 1980).

"Health is our most valuable natural resource" proclaims a poster from the Irish Health Education Board; but frankly, the activities of government, industry and individuals belie this assertion. Much of the environment presents an overwhelming challenge to the production of health, both directly through pollution of the air, water and soil, through hazardous working conditions and the development of hugely destructive military weapons; and indirectly, through the options, or lack of choice, it offers for food, recreation and education (see e.g. Draper et al. 1979). If health is to become "a valued community asset" (Tones, 1977), then conditions must be such that it is seen as an asset worth achieving and potentially attainable - it must become relevant and realizable. In this our planners and politicians have a central part to play. Allen (1980) has suggested that a principal reason for the failure of health promotion programmes in industry is the lack of any health-positive culture: "People are being asked to change when the environments in which they live and work are not at all supportive of the recommended changes" (p.7).

Several respondents to the survey stressed that effective health promotion depends not only upon local interest and support, but also on the compatibility of policies for health promotion with national policies, since these significantly influence the environment within which efforts are made to improve health, and will shape individual preferences for lifestyle changes. A health educator from Poland, suggested a definition for health promotion, which makes these links explicit. "This is the activity in the field of health education (my italics) which is integrated with the economic and social policy of the country and which creates conditions for the development and improvement of health and the aim of which is to increase potential health of the society" (1981, personal communcation). The same point can be made about policies for transport, energy, agriculture and trade, which will generally be beyond the control of local communities, such that the creation of conditions conducive to health depends upon the support of regional and national government, and increasingly, upon support from international government, business and public organizations. It must be acknowledged that support for policies conducive to health may be unobtainable when it conflicts with other demands and influences - money, employment, political power and so on.

At all levels, effective change and intervention for health promotion will result only from the coordinated activities of many different sectors; for example those influencing opportunities for work, housing, food and social contact (e.g. Regional Strategy, WHO 1980c, paras. 60,52,24). Although, for example, the ultimate aim of the Canadian Health Promotion Directorate is to achieve change in individual behaviour, the strategies for attainment of this objective are planned to act on the determinants of individual behaviour, and therefore to operate in the social, institutional and environmental, as well as personal, spheres. The creation of environments favourable to health and providing options for health-promoting behaviour may involve new legislation and fiscal policy, as well as education and improvement of living conditions (Fielding, 1977; Milio, 1976). The health sector may not modify environments directly, but will contribute to the development of health-conducive policy in other sectors, through provision of information about health, details of possible intervention and assessments of costs to benefits (Hellberg, 1980; Draper et al., 1979).

Many of the points relevant to approaches in health promotion have been captured in (North American) debates about health educators or public health doctors and nurses as health advocates for communities (Brown and Margo 1978). In particular, these discussions have emphasized the need to come close to, and work with, the community. Only by helping communities to identify their health needs and develop strategies to meet these needs can the health advocates be perceived as credible allies, as opposed to outsiders working in the interests of other groups or authority. The Health Advocacy Unit, in the Department of Public Health, Toronto, is concerned with both disease prevention and health promotion. The Unit's approach is based upon the principles of "ecological sanity" and "social (cf. market) justice"; and the Unit works on several premises, including that: health is not just physiological and psychological, but includes social, political, economic and ecological dimensions; health issues involve levels of government beyond the city, and it is the proper responsibility of a Department of Public Health to work with government departments to deal with these issues; effective action to deal with health problems requires a collective approach with extensive community involvement; finally, that so-called lifestyle patterns are the result of a lifelong process of socialization within a specific psychosocial environment and culture which profoundly influences (and often consciously manipulates) human behaviour, so that it is not sufficient to deal with such behaviour simplistically in terms of individual responsibility. These premises might form the basis for a discussion in Europe of basic principles for health promotion.

Consideration of a concrete example, for instance a community programme focusing upon the improvement of diet and promotion of healthy eating, illustrates the breadth of issues, measures and organizations involved. (For more detailed discussion see e.g. Brown and Margo 1978, esp. p.18-21; McAlister et al, 1981). To establish priority issues in nutrition, the health advocate will liaise with community groups and organizations of all kinds, as well as devising approaches for making contact with people who are not members of organizations. The group will identify current eating patterns so that recommendations about food and menus relate to the diets typical of people in the community. Inadequacies in nutrition will be discussed with concerned individuals, with health personnel and a nutritionist. It is likely that several different problems will be identified, depending upon the age, work, income, awareness, etc. of different groups, e.g. pensioners, schoolchildren, factory workers, business consultants. In devising strategies to improve nutrition in different respects, various constraints on the improvement of present eating habits will be identified: knowledge about the nutritional value of foods and where these foods can be bought; availability and cost of different foods; skills in cooking and design of menus; adequacy of information available about nutrition; availability and cost of prepared meals. To deal with these issues involves: educators (providing information about food values and product selection, the consequences of obesity and inadequate diet), media (generating support for food products and healthy eating, presenting recipes and food ideas); trainers (of cooking methods and shopping skills); industry (advertising, type and cost of food produced, canteen facilities for workers); food distributors (foods available and promoted); government (hygiene and safety legislation, economic incentives for production of certain foods, income, transport, agricultural and other policies influencing costs); local authorities (school meals, meals on wheels) and community groups (pressure to improve nutrition, reinforcing maintenance of any changes).

3.3 People

Clearly, in promoting good nutrition there is a principal role for health educators, community organizations and industry. In general, the promotion of health requires the skills, resources and active involvement of a vast spectrum of groups and interests. A first step in health promotion must be for these different groups to recognize their contribution to the production of health - for that reason a brief review of (potential) resources for health promotion is offered below. The question of which group might take responsibility for coordination and increasing the awareness of others remains open.

Most health promotion probably takes place in the home rather than at school, in the doctor's surgery or at work. It is in the family or household setting that, for most of us, the primary socialization to value certain ways of living and the generation of opportunities to live in certain ways, takes place. It is there that we develop attitudes and behaviours relevant to, and conducive to, health - habits of eating and sleeping, feelings of love and appreciation, skills in communication and relationships, awareness of the environment and its relationship to health. As teachers, facilitators, supporters and models for the development and reinforcement of behaviour, the family plays a most important role in determining skills, knowledge and material resources which provide potential for the improvement of health. Even if the activities of individuals and their families are not regarded as formal health promotion, it is essential that those working to create opportunities for people to improve their health should recognize and support the contribution of the family or the primary social group.

Many of those more formally involved in health promotion are active at the community level - establishing needs, providing information and facilities, coordinating and supporting community action for health. Needless to say, with different concepts of health and with varying assessments of the degree to which health is an immediate objective of their work, there will be disagreement between observers about whether certain work in education, housing or the provision of recreation facilities is health promotion or not. On the other hand, many people will be engaged in activities they describe as health promotion, e.g. as part of community development (Newell, 1975; Hubley, 1980), to which others would not attach such a label.

At the most general level, reference must be made to the education and training for health which is organized in schools, colleges and institutes of adult education, as well as initiatives by health educators and occupational nurses in the workplace (Ivanova, 1975; Haskell and Blair, 1980); by community artists and theatre groups (Boria, 1981), e.g. by the community theatre in Seraing, Belgium; by community health groups in England, schools of health in Poland, health shops in the Netherlands, and women's organizations almost everywhere. The list of youth, sport, community and voluntary organizations already working to promote health through the provision of facilities for adults, children and the elderly, where they can play, create or contribute to local life, is endless. When health is perceived in its broadest sense to reflect social and emotional, as well as physical well-being, then, equally, the work of all groups who seek to improve the environment is a contribution to the promotion of health - tenants' groups and workers' councils, action groups for the elderly, children and the disadvantaged. The ability to designate some groups as being of more significance than others will depend upon the definition of local health needs and the knowledge or awareness of the contribution that activities by different groups and professions can make to the resolution of these needs.

It is likely that the finance (and support) of local government will be critical for the success of health promotion ventures organized by voluntary, charity or community groups (Hellberg, 1980). No less important is the role of regional and central government in influencing the economic and social structure within which local efforts are made. The role of government in policy formulation and the establishment of financial limits for sectors such as agriculture, employment, transport and health, has already been mentioned. Many forms of social legislation constrain or enable activities in areas such as marriage, sex or child care, while other legislation directs what others should or can do in advertising, food quality and work conditions.

Health promotion is essentially a social rather than a medical activity, but it encompasses the present work of many in the health services and has implications for all concerned with supporting personal adaptation and development. In the personal health care sector, it involves promoting positive attitudes to good health, increasing knowledge of behaviour and living conditions conducive to health, and offering practical alternatives to realize good health - but in the context of professional awareness of the particular physical, social and environmental circumstances which influence the relevance of that advice. In England, this is an important part of the work of health visitors and district nurses, particularly with regard to child development and the adjustment of older people to changing circumstances.

In the nineteenth century, the circumstances and living conditions of the population were focal points for action by medical officers of health in United Kingdom, who were conceived as both protectors and promoters of the local public health (NSPH, 1979). However, Edward James, writing more than a century ago about the education and training of physicians, commented that "... with health, with fullness of unalloyed, unimpaired life we, professionally, have nothing to do" (quoted in Fielding, 1977), and in a report this year from the Royal College of General Practitioners (United Kingdom), it was observed that the promotion of health was "the part of prevention work furthest from most doctors' habits of thought and action" (RCGP, 1981, p. 4). This may reproduce the views of doctors themselves that promotion of health is more of a social than a medical problem. The doctors therefore will retain a preference and inclination for that in which they are

trained and have practised - clinical work with patients who present with disease problems. However, the potential for health promotion in general practice (Stott and Davis, 1979) was identified by the British Royal College of General Practitioners and its development encouraged. In part, this potential to offer patients advice aimed at better adaptation to the environment derives from the nature of the consultation and from the doctor-patient relationship. At the same time, the traditional doctor-patient relationship may be a barrier to involvement in changing lifestyles (Davis, 1979), and the Royal College suggested that in doing health promotion doctors "have to renounce any mystique belonging to their role as healers or benefactors, assuming instead a more equal status with people who may be neither ill, nor anxious, nor forward-looking ... and who therefore lack the motives to cooperate on which the doctor is accustomed to depend" (1981, p.4). The idea of cooperation with medical advice, aimed at "helping people to learn and to accept responsibility for their own well-being" (RCGP, 1981, p.4) is potentially in conflict with some of the wider concepts of health promotion, which emphasize the social context in which personal lifestyle choices are made. Thus, the recommended lifestyle choices of health professionals may not appear compatible with, or indeed relevant to, the resources or interests of individual patients.

There appears to be a large potential for greater involvement of health visitors, nurses and doctors in promoting the growth and development of both children, both at home and at school (e.g. DHSS, 1980; van Parijs, 1980), possibly in part through increased participation of parents in school-based health activities (Lucas, 1981), and of health professionals in community-based activities. However, there is a lack of well-documented information about the contribution of people in the health services to health promotion. There is an abundance of statements about the importance to different professionals of promoting health (e.g. DHSS, 1977) but rather less detail about the frequency and ways in which they do this. In part, this reflects the relative recency of the term "health promotion", but also probably the immaturity of practical developments in the field.

Among public health professionals, reference has recently been made to the role of occupational health personnel in the promotion of well-being in workplaces (WHO, 1980a); and to the contribution of environmental health officers, particularly in increasing awareness of environmental principles and in elucidating the relationship between environmental problems and lifestyles (WHO, 1980b). The specialist in community medicine or public health could play a most vital part in encouraging the development of conditions and policies - social, economic, political and environmental - that promote health (USHP, 1979). Community physicians, health planners, and possible health administrators (Abel-Smith & Leiserson, 1978) may function as public watchdogs to monitor and direct the developments of other sectors, insofar as they have implications for health.

A more comprehensive review of people who are, could be, or claim to be, working for health promotion would include consideration of new approaches in health care, e.g. holistic health and wellness medicine, as well as the new psychotherapies - encounter groups, transactional analysis, est, Gestalt therapy, and so on - (Clare and Thompson, 1981). In the field of mental health, reference must be made to religious and spiritual organizations and to the groups based in oriental philosophy and meditation. More generally, nothing has been said in this report about the role of the mass media in health promotion (see e.g. Puska et al., in press).

The number and type of groups, organizations, professions and other personnel working in fields relevant to health promotion is so large that it appears that no useful way of organizing information about health promotion activities can be arrived at by listing the actions of different agents. In any case, given the present state of the art, all classifications must be provisional and limited. However, an attempt is made in the next section to suggest frameworks which may give some order and meaning to the information about health promotion activities.

4. A classification of health promotion

There is no neat classification - whether of measures or methods, of agents or target groups, of objectives or outcomes.

4.1 A preliminary classification:

Following the ecological model of health (see Appendix II), it is possible to specify the general directions in which health could be promoted. To recapitulate, in this conception, health depends upon the ability to realize personal needs and aspirations on the one hand, and the ability to deal with strains and stresses in the external environment on the other. To maintain or promote

health, therefore, the individual requires personal skills and knowledge, a supportive environment providing opportunities, services and facilities for health behaviour; and social, physical and economic conditions conducive to health (or at least not health-damaging). These considerations suggest three main categories of health promotion activities: those carried out by people to improve their own health (and possibly that of others); those carried out to enable or increase the ability of people to promote their own health; those carried out to improve health through changes in the environment without requiring any personal effort.

Examples of each category are the following:

I. Individual or group practices, not motivated by the need to respond to a specific disease or health problem. These include fairly traditional health maintenance activities, e.g. physical exercise, sports, gardening; monitoring and moderating food and drink consumption; relaxation techniques, yoga, meditation, listening to music; hobbies and participation in youth, arts, social and other societies; making and maintaining social contacts; involvement in self-help, voluntary or church groups; attendance at counselling or classes to learn about factors influencing health; use of medical and social services to monitor health.

Additionally, individuals may seek to promote their health through changing the environment: participation in community activities designed to improve the provision of facilities, for example, recreation, child care, employment, social contact, arts; through involvement in political and other groups aiming at improving the organization and provision of health, social or welfare services; or in groups directing their efforts towards changing the social environment regarding acceptability of certain forms of behaviour and lifestyles, or the physical environment of noise, traffic, air pollution, and so on.

II. Measures designed to support health promotion by individuals and groups:

(a) Education and training activities - designed to increase the ability of people to make decisions regarding their health, and to equip them with skills to carry out these decisions. These include formal programmes designed to increase knowledge of the relationship between health and behaviour, or health and environment, or health and the resources of social, medical and welfare services; training in life skills such as problem-posing, decision-making, and social participation; training to cope with both predictable life transitions, such as leaving school, entering work, parenthood and retirement, and with crises; education for recreation, creative leisure, social action; training in relaxation and yoga, dancing and cooking; feedback from developmental health surveillance and health check-ups or assessments.

(b) Changes in the environment - designed to facilitate the promotion of health by individuals or groups. These might include the provision of a safe environment for cycling, jogging paths, play areas for children, parks; pricing and availability of foodstuffs; establishing clubs and buildings where people can meet and participate in leisure activities; providing financial and other support to voluntary organizations or community groups working to promote health; improving access to medical, social or welfare services; enabling legislation, regarding, e.g. holidays, fostering, home improvement.

III. Changes in the environment designed to result in a direct improvement in health - largely by legislation or social change to reduce the challenge of health-damaging elements in the environment. (This category highlights the problem of maintaining a useful distinction between health promotion and disease prevention). These might include reduction in permitted noise levels, improvements in the quality of housing and work conditions, increasing the safety of roads and transport, removal of lead from petrol, changes in the code of advertising standards. On the more positive side could be the financing of landscaping and better architecture, but most health-promoting changes of a positive type will be facilitating rather than of direct effect.

In any health promotion programme it is likely that different combinations of approaches from all three categories will be relevant. As presently conceived, the categories are extremely wide-ranging and all-inclusive. Criteria for including specific activities in the categories will depend upon our understanding of factors promoting health. They do not depend upon the proven effectiveness of the activity, since the definition of health promotion refers to activities designed to, rather than evidenced to, improve health. Equally, different activities will be appropriate to different circumstances and any particular action will not necessarily be of interest to all groups. Therefore, it would be difficult to exclude many activities a priori as not promotive of health. Employing the ecological concept of health raises a large number of both logical and empirical questions: e.g. under what circumstances, if at all, does lowering aspirations and ambitions improve health; under what circumstances, if at all, does increasing the challenge of the environment improve health? Responding to these questions here would be both too

ambitious and too challenging! It is somewhat more modest to ask what kind of activities individuals engage in to promote their health and how they are supported. These questions are reviewed next.

4.2 Personal health behaviour

Documentation of the activities in which people engage to promote their health is exceedingly underdeveloped. These activities are usually discussed as health behaviour or health-promoting behaviour, but these concepts and their indicators are employed inconsistently in the literature. "Health-promoting behaviour" may be used as a general concept in opposition to "health-hazardous behaviour" (e.g. Ben-Sira, 1981) with the focus on disease prevention. Alternatively, it may refer to specific types of behaviour in the context of a more positive concept of health (as in Wyshak et al, 1980). Health behaviour, as a concept distinct from illness and sick-role behaviour, has been defined as "any activity undertaken by a person believing himself to be healthy, for the purpose of preventing disease or detecting it at an asymptomatic stage" (Kasl and Cobb, 1966, p.246). Most studies appear to employ this formulation and attempt to identify forms of health behaviour that are medically approved activities designed to prevent disease. Health behaviour is equivalent to preventive behaviour, "inasmuch as it consists of utilization of health services for the assumed purpose of maintaining or improving one's health and avoiding the effects of illness" (Steele and McBroom, 1972, p.382). Therefore, health behaviour is operationalized in terms of either contact with health professionals for advice, immunization or check-ups, or carrying out approved health practices, such as maintaining a proper diet, brushing teeth, taking exercise.

In this approach to health behaviour, the researcher checks personal behaviour against a list of activities considered appropriate for the protection of health. The researcher defines health activities so that "the range and typology of health behaviour is limited only by the imagination of the researcher and the purposes of the research" (Steele and McBroom, 1972, p.383). Whether individuals consider their cooking, walking, massage or bathing as purposeful health behaviour is a separate question. Levin and colleagues (1977) have affirmed that a holistic approach would broaden the perspective on health behaviour to focus upon personal rather than professional perceptions. Health behaviour defined in this way would not necessarily be either medically approved or objectively effective. This strategy is adopted by Harris and Guten (1979), who define "health-protective" behaviour as "any behaviour performed by a person regardless of his or her perceived or actual health status, in order to protect, promote or maintain his or her health, whether or not such behaviour is objectively effective toward that end" (p.18).

There are, then, two main approaches to the investigation of health behaviour: information is obtained on the basis of questioning about specific preventive or promotive measures; or individuals identify activities they perform to protect or promote their health. In the first, researcher-defined, category, we can include the information derived from census data and surveys about food consumption, family expenditure, leisure activities, membership of social clubs and so on. By assuming that certain forms of behaviour are more or less conducive to health, a description of health behaviour can be made. Many surveys have collected information about behaviours like smoking, drinking and use of drugs. However, this has generally been in the context of studies looking at possible risk factors for specific diseases, rather than at behaviours conducive to or protective of health. As such, smoking, drinking and drug use have been excluded from further detailed consideration in this report, although it is recognized that avoidance of these practices is described by many authors as "healthy behaviour". In general, there has been little systematic research into health behaviour in Europe (with the notable exception of annual surveys in Finland), while nearly all the North American data on health practices and the use of preventive/promotive services are limited to medical services as defined by the researcher. Moreover, the available information relates almost exclusively to activities in which individuals engage personally and for their own benefit; the concept of health behaviour has not been widened to include social or collective action aimed at modifying the environment.

The classical research on health practices has been conducted as part of the Alameda County Study (Breslow and Enstrom, 1980). Their findings about the positive relationship between good health practices and physical health status were referred to earlier. The "seven health practices" have now been incorporated into the U.S. National Health Survey and variations analysed by sex, age, income, education and race or ethnicity of the individual (Schoenborn & Danchik, 1980). These data will now be collected at regular intervals and examined in relation to physical health status. Other studies have examined the health-promoting behaviours of different groups; Wyshak and colleagues (1980), for example, asked doctors and lawyers about their physical and recreational activities, use of seat belts, possession of firearms(!), smoking, drinking, hours of work and sleep, observance of dietary restrictions and relaxation activity such as meditation. By a narrow margin, doctors seemed more concerned than lawyers with personal health-promoting behaviour.

Mechanic and Cleary (1980) looked at positive health behaviour in childhood, and in the children in question 16 years later. They found little evidence of stability of health behaviour over time; but overall, women had more positive scores on the researchers' indicators, reflecting a higher level of drinking and risk-taking among men and a lower level of use of preventive medical care by men. However, they were not successful in identifying factors which influenced the development of positive health behaviour. In part, this is probably because preventive/positive/promotive/protective health behaviour does not appear to represent a single dimension or orientation. People who take part in one activity considered beneficial are not consistently more likely also to engage in other approved health behaviours (Mechanic, 1979; Steel and McBroom, 1972).

Bauer (1980) has brought together the results of several recent American surveys of attitudes and behaviour relevant to health promotion. She reports one study (Yankelovich et al, 1979) in which 46% of American adults said that they had recently changed the lifestyles of themselves or their families in the interests of good health. In particular, one in every four adults reported eating more nutritious food than they had one year previously and a similar proportion said that they were now watching their calorie intake more carefully. Only a small proportion of people reported changing their drinking habits for health reasons, while the large number of people who were exercising more was almost matched by the proportion reporting that they exercised less than they had one year previously. There seems to be evidence of trends in diet, exercise and smoking among the U.S. population which are in the direction of reducing established risk assessment for cardiovascular disease in particular (Stamler, 1978, Lancet 1980). There has been much less interest in the consequences of these changes in behaviour for more positive aspects of health, and no agreement about the causes of these changes (McDermott, 1980) - a core issue in the debate about changing lifestyles (Mayer et al. and commentaries, 1980).

There appear to be few studies which adopt the self-defined approach to investigating health behaviour. Harris and Guten (1979) asked a randomly selected sample of 842 adults in Greater Cleveland, USA "what are the three most important things that you do to protect your health?". Almost all respondents (97%) reported performing some kind of health-protective behaviour. Over 70% mentioned behaviour concerning general nutrition, specific foods, or how and when they eat. Next in frequency (46%) were reports about how, when and how long or often respondents sleep, rest and relax. In third place, mentioned by 35%, came behaviour concerning exercise or similar physical activity or recreation. Almost one in five reported behaviour involving contact or compliance with professionals in the health care system. "Responses to the open-ended question on the 'most important' health-protective behaviours suggest that people perform a wide range of activities in the belief that these activities can protect their health, that most (health-protective behaviour) does not require or involve contact with the formalized health care system, and that protecting one's health is apparently a personal rather than a professional matter" (Harris and Guten, 1979, p.22). Eating, sleep and relaxation, and exercise, appear to be the most usual responses to questions which address the issue of behaviour for the maintenance of health. The few studies of this type reported in Europe, e.g. those of Stott and Pill (1980) and Herzlich (1973) have relatively small sample sizes. In both these studies diet is the most frequently mentioned health measure. Herzlich's respondents apparently found the adoption of healthy eating patterns difficult in some cases, but intrinsically satisfying in others, e.g. "When I eat in a healthy and natural way, I know a great difference in my health, in what I do, but ... with the kind of life I lead, I'm not able to watch what I eat." (p.97); "For me, paying attention to what I eat is quite natural; I don't calculate calories or vitamins, but I take care. Really, I take pleasure in it; it's quite likely that if I didn't enjoy it, I might not do it." (p. 101). The development of an environment which offers opportunity for healthy nutrition is, and evidently should be, a priority area for those involved in health promotion. The complexity of this task, related to availability, pricing, quality, knowledge, and dissemination of knowledge about foods, was referred to previously.

In terms of protecting health, use of health services ranks below behaviour in these three aspects of life, though it was mentioned in the study of Harris and Guten (1979) more frequently than concern with personal hygiene, general philosophies of life or psychological, emotional and spiritual well-being. It may be that contacting the doctor for a preventive check-up simply does not happen very often: Steele and McBroom (1972) found that less than 10% of the respondents had had a preventive medical (excluding dental) check-up in the previous twelve months. In a recent study in England and Wales, 22% of adults said that during the last two years they had had a check-up or a general examination "to see how they were - not because anything was the matter with them" (Cartwright and Anderson, 1979). As an indicator of level of health behaviour, check-ups would not appear adequate; analysis by Harris and Guten (1979) shows that "measuring only preventive health care behaviours but generalizing to a broader set of health behaviours is not empirically justified. Furthermore, people who obtain preventive examinations are no more or less likely to perform other types (of health protective behaviour) than are people who do not get them." (p.23).

The standard question still remains without an answer, however - what is the relationship between positive health behaviour, health protective behaviour and health promoting behaviour? Answers to this question will, of course, remain philosophical until some operational definitions are employed in research. How would ideas held about these health concepts influence response to questions alternatively formulated? This is an empirical question which can only be approached in larger scale, systematic surveys. These do not seem to be conducted on this theme at present, though the unpublished data from studies monitoring the effectiveness of health education measures, e.g. the annual "Effizienzkontrolle" of the Federal Centre for Health Education in Cologne, offer a great deal of relevant information. Health protective behaviour and the usual definition of health behaviour (Kasl and Cobb, 1966) are concerned primarily with disease prevention. The criteria for designating behaviours conducive to positive health, to personal growth and development, may be quite different, emphasizing for example enjoyment, variety and interest, challenge, consequences for self-concept and social relationships, involvement with others, positive contribution to the local environment or community.

4.3 Health promotion activities, ordered by: a) level of organization and b) nature of the activity

The concept of "activities" is used here only as a convenient label to encompass the actions of (organized) groups to promote individual health or the public health. It therefore includes the transmission and dissemination of knowledge and skills, the provision of facilities and conditions which enable individuals to promote their health, and actions to change the environment to make it more conducive to health. Devising a scheme or classification which brings order to this range of activities, which permits identification of activities to be represented, and which illuminates gaps in information, appears a little ambitious considering the present state of theory and practice in health promotion. Furthermore, the appropriate or expected variety of health promotion activities will, in any particular setting, depend upon the character of the social environment, cultural values and traditions, the political system, the state of the economy and technology and the availability of facilities and services. Insofar as these environmental conditions act as constraints upon the improvement of health, positive changes in their characteristics could be identified as health promotion activities.

In devising a typology of health promotion activities, respondents to the survey suggested several points of departure - agents of the intervention, target groups, media and resources used, sphere of life in which intervention is made. It was observed that in the terminology employed in Eastern Europe, health promotion is equated with active health protection. A respondent from Hungary suggested a typology ordered by participants and activities, as follows.

(1) Health education and consciousness-raising by: national health education organization (through mass media, pamphlets, campaigns); national cultural and training organizations; national (state) voluntary sports and religious organizations; schools and youth groups.

(2) Health promotion practices and activities, by individuals (exercise, relaxation, weight control, hygiene) or groups (sports, tourism, hygiene competitions).

(3) Health promotion in the environment directed towards:

(a) reducing pollution through cleanliness in towns, villages and at work; aesthetic improvement, planting trees, and laying out parks; protecting the environment, especially in the planning process;

(b) changing social conditions which influence health, including action against health-damaging living conditions, alcohol, tobacco, medicines and drugs, reduction of risk factors for disease, provision of health care.

This proposed classification includes many of the activities incorporated in the categories developed from the ecological model of health. On the other hand, it is more clearly disease-oriented, including concerns with alcohol, drugs and smoking; and gives less emphasis to non-educational facilitating changes in the environment. Only two further approaches are outlined below: the first orders activities by the scale or level at which they are organized, and the second by the nature or life area of the activity. In both cases, some illustrative examples are given, though many are by no means clear examples of health promotion, as opposed to health education, recreational provision or risk reduction. (In considering activities, it became increasingly difficult to retain some of these conceptual distinctions.)

The agents of these illustrative activities would probably describe a large proportion in terms other than health promotion, though in most cases such a label would also probably be acceptable. More details of individual activities are available in the referenced articles and in publications such as Health Education in Europe.

(a) Levels of organization

Health promotion activities may operate at national, regional, community or local unit levels. In many cases, the same activity may be coordinated and linked at all levels (e.g. certain sports, voluntary and educational activities organized from national to local club or group levels). In other cases, one objective, e.g. improved nutrition, nursery education or cleaner environment, may only be realized by action at all levels. Certain types of health promotion are obviously more likely to happen at national level, e.g. agriculture and energy policies, legislation; while others, probably most, take place at the community level or below, e.g. provision of youth centres or gardens for the blind. Examples of general health promotion activities, particularly those concerned with diet and exercise, can be found in most European countries at some level.

In Sweden, the National Social Welfare Board began programmes to stimulate health eating and exercise in the early 1970s, with guidelines such as that on "Planera för motion" (Planning for Exercise) and "Kost och Motion" (Diet and Exercise). These were national campaigns directed at individuals, recreation groups, food manufacturers, municipal councils and national government. The Swedish campaign, which concentrated on diet and exercise, because "practical experience and endless discussions during ten years have made quite clear the necessity of limiting the campaign as a whole" (member of the Central Exercise Council, Sweden). Thus, health promotion has been defined as "efforts by the community and by various associations to encourage the individual to adopt a way of life which promotes health and well-being. Primarily, this refers to efforts to encourage regular exercise and a proper diet" ("Planning for Exercise", p.4); and the object of these efforts is "to give the individual greater opportunities and freedom of choice, through various health policy measures, to improve his or her well-being" (p.37). These measures included education and information, making maximum use of available facilities and encouraging the development of new ones, organizing group activities and check-ups on health and fitness. The document refers to the integration of health promotion with other business and activities in society: "It is intimately related to the social planning that is carried on at different levels and in different sectors." (p.28). Dixon (1978) observes on the nature of this relationship when he suggests that the diet element of the scheme would have achieved greater success if the nutrition education, to reduce fat consumption, had not been in conflict with subsidies to farmers to increase consumption of beef, pork and dairy produce. With regard to sports, the document refers to swimming, cycling, walking, ski-touring, badminton, etc., and to their health promotion value, in that "they offer fitness, relaxation and recreation, spare-time occupation, social intercourse and so on" (p.21). The contribution of family leisure activities to promote mental and social as well as physical health is similarly a core element of the Scottish Health Education Unit's "Fit for Life" project. Diet, exercise (and stress reduction) are also the main components of the "Look after Yourself" campaign sponsored by the Health Education Council in England. All three national programmes are also designed for implementation at community level, in schools and in the workplace.

Many of these general health promotion campaigns stem from an original concern with cardiovascular disease and its risk factors. Several regional and city projects have been organized on this basis, e.g. the "Health Promotion in Youth" projects supported by WHO in Oslo, Berlin, North Karelia and other centres, and the longer-standing "Comprehensive Community Programmes for Control of Cardiovascular Diseases". Of these the best-documented in Europe is the well-known North Karelia Project, which has been going on in Eastern Finland since 1972. This project was launched in response to a position from the local population requesting help to reduce the levels of morbidity and mortality due to cardiovascular diseases. The intermediate objectives were the reduction of risk factors in the whole population, particularly smoking, serum cholesterol levels and high blood pressures. To this end, special attention was given to promoting a non-smoking lifestyle and low-fat diets. The project was comprehensive in involving and gaining the support of the whole community as well as of those engaged in food production and distribution, health service personnel, schoolteachers, media personnel, government officers and policy makers. A broad spectrum of approaches and methods was employed, including reorganization of preventive services; provision of information about health maintenance and the purpose of the project; persuasion and advocacy to reinforce the credibility, acceptability and appropriateness of the project's goals; training to facilitate the acquisition of new habits and skills; organization to involve the community and to create support and power for social action; and environmental changes, specifically to increase the availability of low-fat foodstuffs and to introduce restrictions on smoking (McAlister et al., 1981; Puska et al., 1981)

Although the primary goal of these projects is the prevention of specific diseases, the approach is compatible with previous statements about methods in health promotion. Furthermore, the North Karelia project was directed at the entire population, not only those assessed as being at high risk for cardiovascular disease, and the positive consequences of the programme's activities are not limited to, or specific to, that disease. These characteristics are stressed in the account by Bretscher and Kirchoffer (1978) of a community intervention programme in Switzerland: "rather than stigmatizing individuals with risk factors, attempts will be made to motivate the whole population toward a healthier lifestyle" (p.284); "... accent through the program is placed on the positive benefits of a healthy lifestyle rather than on the dire consequences of risk factors" (p.285). The development of positive methods, rather than the more traditional warnings to, and stigmatization of, individuals with behaviours considered unhealthy is increasingly evident in health education and disease prevention campaigns. In East Sussex, England, a health campaign was launched this year focusing upon recreation, and building upon a similar campaign launched three years previously in nutrition. The new campaign employs a teaching pack for professionals and pamphlets for voluntary and community groups, and is concerned with planning of housing estates, as well as provision of recreation facilities and transport. The local medical officer was clear about his priorities: "I wanted the emphasis to be placed on the promotion of healthy living rather than negative campaigns: don't smoke and don't drink. Of course, these are crucial, but in East Sussex we were not ready for them. We decided to encourage people to become more healthy rather than less ill." (quoted in Dean, M., 1981).

General health promotion efforts at the local level may take place in community, social or health centres throughout the area, or in particular units such as schools, factories or neighbourhood centres within it. As previously noted, however, provision of facilities and opportunities for personal health promotion may depend upon the support of government and organizations above the local level, albeit in response to action and initiatives from within the community. Although there is evidence of increasing community involvement in health care (Greve, 1980; Levin et al, 1977), community action for health appears to have developed more slowly than, say, involvement in housing, youth work, planning and child care.

In the United Kingdom, community health initiatives emerged about five years ago, from several sources; women's groups, ethnic minority associations and housing groups being the most prominent. They have developed first mainly in the working-class inner-city areas of major conurbations, where, perhaps, the needs are greatest, and the emphasis is upon action which is based on needs that the community itself has identified. The projects are working not only to influence the delivery and level of health service provision, but also to enable individuals to prevent much ill-health and to promote good health. As such, a principal goal is to stimulate greater awareness of health, its meaning, and social factors influencing its development or decline. To take one example from several in London, the Neighbourhood Health Project at the Albany Community Centre in Deptford, South-East London, began with an existing mother-and-toddler group and a public meeting about health care in the area. The Albany Health Project works mainly in a housing estate with a population of less than 5000 and employs two community development workers with an interest in health and a knowledge of and commitment to the area. These workers are supported by an advisory group of local people, health professionals and other community workers. There is also contact with three other community health projects in South-East London. The goals of the project include increasing awareness and demystification of health issues, promoting self-confidence for participation in, and decision-making with regard to, both personal health choices and local health care; building and strengthening community organization; linking with other community resources, e.g. education institutes, local authority staff, church networks, trades councils, etc; improving communication and fostering greater sensitivity between health professionals and the community. With an approach grounded in community work, the project has aimed at supporting community interests in health promotion by organizing: health discussion groups, particularly for women and young people, in which the participants decide on the "syllabus", and to which health professionals may come and speak; a street party and social events; information projects in local schools; relaxation, massage and body awareness workshops; yoga classes; a keep-fit group; a health club for the elderly; an Open University preschool playgroup; and a children's health club.

b) Nature of the activity

These are only some of the activities undertaken in one small community health project. In the same part of South-East London there are other groups offering health courses for pensioners, yoga and relaxation classes, playgroups for children, preparation for parents, an arts workshop for the community and a theatre group, "theatre-in-education", exploring social and mental aspects of health. How can the activities which are labelled as health promotion be categorized? Under what themes or domains of living can they be grouped? The Canadian Health Promotion Directorate has now

established its priorities for wellness based upon: (1) good nutrition, (2) physical activity, (3) rest and relaxation, (4) family and friendship networks, and (5) avoidance of risks associated with smoking, alcohol and drug use, and accidents. In its search for model health promotion intervention strategies, the American College of Preventive Medicine included projects which sought to promote health in the following lifestyle areas: (1) physical activity, (2) nutrition and diet, (3) stress, (4) abuse of alcohol, cigarettes and legal drugs, (5) compliance with safety programmes (e.g. seat belt use) and (6) compliance with regimens of risk factor treatment (e.g. adherence to exercise programmes or use of hypertensive medicines). The "Lifegain" programme from the Human Resources Institute in New Jersey, USA (Allen, 1980) identifies six dimensions of health: (1) human relationships and sense of community, (2) stress management, (3) exercise and physical fitness, (4) nutrition and weight control, (5) tobacco, alcohol and drug use, (6) safety and use of medical resources.

From a consideration of these and other categorizations, together with discussions and identification of health promotion projects in Europe, six categories are suggested below for ordering health promotion activities, recognizing that several areas of activity may be the focus of one project and that other possible areas such as alcohol, smoking and use of drugs have been excluded. All are concerned with the way in which we live and the environment in which we live, except the first, which deals generally with our personal resources and our ability to use other resources to make the most of life.

(1) Life-skills and preparation for life includes activities designed to increase personal competence or the ability to handle the problems and opportunities of living in general, and to deal with life transitions, e.g. parenthood, retirement, bereavement and (un)employment. Education in life-skills tends to be a group activity, while preparation for life events may stem from individual counselling, anticipatory problem-solving (Pridham et al., 1979) or anticipatory care in medical practice (RCGPs, 1981), as well as groups or classes in factories, youth centres, antenatal clinics, further education colleges and people's homes.

The life-skills are those which enable people to learn to control and direct their lives, developing the capacity to live with and produce change, e.g. identification and posing of problems, problem-solving, decision-making; social participation, conflict resolution, communication and literacy, creativity. Such diverse skills have been approached using a large variety of learning styles and methods (Lee, 1980; Persson, 1981). These include reflective recreation (Low, undated), active tutorial work (Baldwin and Wells, 1979) and life-skills teaching programmes (Hopson and Scally, 1980). The focus is upon children and adolescents: in schools (Williams and Williams, 1980); in youth groups (McIlduff, 1980); and in kindergartens, nurseries and playgroups.

(2) Environment and environmental awareness involves the creation of an environment which is at least not health-damaging, and which preferably offers oppportunities for enhancing the quality of life. Awareness of the environment and its contribution to health is a prerequisite for both appropriate environmental change and the ability to appreciate or enjoy the environment. The main interest here is in the physical and built environment, and the first consideration is the promotion of safe conditions at home and at work, on the roads and waterways, in town and country, soil and atmosphere. Reducing the dangers or demands of the environment is clearly one approach to the promotion of health (though it may not be a common element in concepts of health promotion). Effort at environmental change involves a complex mix of interests and resources; for example, reducing noise levels demands public or worker interest and awareness (e.g. the efforts of the Darlington Quiet Town Experiment, Robson, 1979); availability of information (e.g. from a noise advisory council); demands for change (e.g. by the Noise Abatement Society); support of industry and government; and, of course, the technical resources to remove or replace noise hazards.

The protection and conservation of healthy environments are intimately linked to the removal of health-damaging factors, since so much of the pollution, noise and vibration which damage our health, create similar difficulties for animal and plant life, as well as for the built environment. Furthermore, these healthy environments offer opportunities for personal health promotion via nature study, outdoor pursuits, history and urban study. Efforts to improve the quality of the environment may be aesthetically more satisfying, contribute to better and more pleasant housing and work facilities, and increase opportunities for living, e.g. by improving access to buses, theatres and homes, and by offering employment to the disabled, the young or the elderly.

(3) Diet and nutrition. The role of specific personal skills and environmental opportunities is evident in all further categories of health promotion activities. Previous discussion has referred to the importance of information on nutrition, pricing policies and availability of foods for the promotion of a healthy diet. Information about the value of foods comes from several

sources, not all of which could be described as well-founded (Herbert, 1980), or in agreement (e.g. butter and margarine manufacturers), or, as in the last example, without some commercial interest in promoting particular foodstuffs. The advertising and marketing activities of food manufacturers dwarf the contribution to public information of local health boards and government. Nevertheless, campaigns to increase public awareness of, and behaviour with regard to, nutrition are probably the most common form of health promotion: e.g. "Enjoy Eating - but Eat the Right Way" (Hungary), "Nutrition and Overweight" (Austria). Consumer centres provide advice about food quality, availability and prices; and, as a visit to the local bookstore reveals, there is really no lack of literature on the subject of diet (or specific diets) and health. The Cooperative Society in Denmark has adopted a "mini-risk/maxi-benefit" food policy, for distribution of those products thought to be of benefit to the consumer and as protection for the consumer against the presence of harmful additives, fats, sugar, contaminants, etc. Another supermarket chain in Denmark has added blood to a large number of meat products, thereby increasing the supply of heme iron. Similarly, there is evidence from North Karelia of the contribution made by food producers and distributors towards the promotion of better nutrition (McAlister et al., 1981). Effective consumer choice requires information about nutrition, availability of quality products, and informative product descriptions, i.e., truthful, accurate and complete food labelling and appropriate pricing. In all these areas, government plays a role, either independently (e.g. DHSS, 1977) or as part of a comprehensive food policy, as attempted in Norway (Royal Norwegian Ministry of Agriculture, 1975; Ringen, 1979). In both Spain and Norway, food policies promote the development of community farming, emphasizing local production of foods. Furthermore, the EDALNU information programme in Spain reaches into work canteens and school dining rooms. Finally, governments contribute to improvements in diet through direct or subsidized provision: of milk and meals in schools; of vitamins for mothers and children; and of luncheon clubs and meals on wheels for the elderly.

(4) Leisure and recreation refers to hobbies, cultural, creative and social activities, as well as sports and physical exercise. Leisure activities have implications for all aspects of health, and certain family activities, e.g. swimming, walking, cycling, are promoted (e.g. by the Scottish Health Education Group) precisely because they contribute not only to physical health, but also to mental well-being. Cycling has been employed in Ireland and, more recently, Scotland, as the focus for a wide range of other activities, e.g. "health weeks" were held in towns on the route of the cycle competition - the "health race" - and involved other sports activities, dancing, demonstrations of relaxation techniques, dietary advice, nature conservation, playgroups and so on, representing a wide range of health promotion activities. The development of a simple precedent for health promotion like safe facilities for cycling has taken place at a vastly different pace in the European countries, (e.g. Holland, cf. United Kingdom (Hamer, 1981)). Sports and physical fitness programmes are core elements in the health promotion activities of many countries (.e.g. German Democratic Republic), though the forms of exercise promoted vary between areas with different traditions, facilities and climate. The factors influencing the development of physical exercise are complex and infer action on many fronts. "Physical activity ... involves socioeconomic and cultural components and is dependent on such factors as type of work, body build, physical fitness, amount and use of free time, accessibility of inexpensive recreational and sports facilities, and proximity of natural features conducive to active recreation. Over many of these factors, the average person has little or no control" (WHO, 1978b). The nature of these constraints, together with reports of the beneficial effects of exercise (Fentem and Bassey, 1978) has stimulated the development of employee fitness programmes, initially in the United States (Allen, 1980), but now also in Europe, at the level of individual workplaces (e.g. in Scotland and Belgium). The social and emotional benefits of exercise have contributed to decisions favouring the provision of free sports facilities for the unemployed (Brown, 1980).

In comparison with the emphasis upon sports and physical exercise for health promotion much less has been done, on health grounds, to increase the opportunities for cultural, travel, educational and other recreational activities.

(5) Rest and relaxation. Rather than emphasising the opportunities they afford for social participation and energetic involvement, cultural activities like dancing, art and music are now more often presented as a means of relaxation. Indeed, it may appear that almost all pleasurable activities are now on offer as organized inducements for relaxation, frequently with the label "therapy" attached! In part, this stems from the general attribution of health problems to the stresses of living in a rapidly changing environment, and in part to evidence of the effectiveness of relaxation techniques in reducing health problems (Benson, 1975). There is a sense of both urgency and significance about developing the capacity to relax: "Failure to develop the skill of relaxation kills you sooner rather than later and this failure is enhanced by environmental stresses. ... The most serious and fundamental effect, however, of a failure to relax is a failure of the individual to develop as a person." (McGann, 1980, p. 170). So, it is claimed, relaxation may improve not only physiology but also personality, increasing the capacity to relate to people

and to communicate, and increasing the potential to learn, solve problems, perform skillfully and create. People achieve relaxation in idiosyncratic ways, but widespread techniques include yoga, autogenic training, biofeedback, meditation and progressive relaxation. Relaxation therapy has been widely employed to relieve health problems in both medical settings (Benson, 1975; Patel, 1981) and the workplace (Peters et al., 1977). Stress management strategies are typically incorporated into programmes designed to nurture "executive health", although such approaches to stress reduction must be considered less adaptive than reducing the incidence of stressful conditions.

The relevance of good rest and sleep has been emphasized by studies asking people how they maintained their health (Harris and Guten, 1979), but there is relatively little documentation of factors influencing ability to sleep well or how this could be enhanced (without the use of drugs). Yet there is evidence that the quality of sleep is less than good for one in every five people in a rural environment (Palmer et al., 1980). In urban living conditions the quality of this "natural" health maintenance activity is probably lower.

(6) Social and sexual relationships include personal and community efforts to increase the levels of harmony and satisfaction in human relationships. They begin with strategies designed to remove barriers of intolerance and prejudice against particular social groups, and continue with activities designed to strengthen and increase the potential of family, friend and community relationships. It is clearly difficult to circumscribe a theme which embraces so many aspects of social and emotional well-being. Even limiting consideration to the activities of organized groups, the enhancement of human relationships is the business of churches, charities, commerce, and community organizations, as well as social workers, psychologists and counsellors nearer to the health care system.

The International Year of the Disabled has drawn attention to the various activities which aim at increasing the participation, equality and integration of disabled persons. In France and the Federal Republic of Germany there are
long-standing programmes, sponsored by the health education organizations to reduce prejudice and improve the social integration of the handicapped and the disabled. Similar goals of involvement and contribution underlie the work of voluntary organizations and charities concerned with the elderly, ex-prisoners and ethnic minorities. Equalizing and increasing the opportunities of these and other groups to lead a socially and economically productive life must be a critical issue for health promotion. Education for social participation and the management of relationships has been referred to as part of programmes in life-skills. It is, of course, a component of all socialization activities at home or in nurseries and playgroups; in some projects, the development of skills for social relationships is the explicit focus (e.g. "Come nearer, I like you", West Germany).

Sexual relationships and activities have not generally been promoted for their long-term health implications. Furthermore, sex education in schools has, when available, tended to be technical in orientation, neglecting consideration of the circumstances in which sexual activity may promote health in general (see Rowland and Haynes, 1978). Several programmes in family planning include discussion of sexual relationships (e.g. "Living Together" on Gotland, Sweden). Insofar as the ability to plan and control fertility is itself conducive to health, it is probably appropriate to consider family planning as another aspect of health promotion. As this section has shown, the rubric of health promotion contains such an enormous variety of human activities that identifying its boundaries would be premature. This is but one of several dilemmas to which those involved in the encouragement and coordination of health promotion must address themselves.

5. Some further considerations

5.1 Defining and evaluating the goals of health promotion:

In attempting to view health promotion from the perspective of health, as opposed to disease, there have been inevitable compromises and inconsistencies. In part, this is because references to health promotion, though diverse, arise frequently in connection with the role of individual behaviour in the etiology of diseases. This disease approach to health promotion has the advantage of a clearly defined goal (reduction in incidence of ...) and therefore, in principle at least, an outcome which is measurable. Disease prevention programmes may also be evaluated in terms of changes in indicators or factors which are thought to be related to the incidence of the disease. Although the understanding of causes, not to speak of mechanisms of origin, of many major diseases is far from complete (see, e.g., Rose and Marmot, 1981, on accounting for mortality from heart disease), it has been felt that the best available knowledge justified taking positive action in, for example, the community cardiovascular control projects.

The evaluation of preventive activities in terms of success and failure regarding outcome (Fielding, 1978) and in terms of economic efficiency relating costs to benefits (Warner, 1979) is subject to a series of methodological problems (Green, 1977; Scheffler and Paringer, 1980). However, by evaluating performance according to the effects of specific health or education services in reducing illness, and the economic burden of illness, certain dilemmas to which positive health efforts are exposed have been avoided, e.g. identifying the agencies and activities for which costings are to be made, rating the economic consequences of enhanced quality of life or life satisfaction. Neither the specific goals nor the most appropriate means to attaining these goals can be identified unproblematically in health promotion. The broad concept of health as physical, social and mental well-being embraces all contributions to human contentment and happiness. It will be for the interests, conditions and values of particular individuals or groups to determine what should be changed or provided to improve health and quality of life. Thus, often health promotion activities cannot be justified or evaluated according to conventional epidemiological or related criteria.

Most sound health promotion will be based upon knowledge of the factors determining health. There is, however, simply a lack of research which deals with healthy people, looking at factors influencing the development and maintenance of health - factors which may range from leisure activities to local government organization, licensing laws or landscape design. The limited research available has focused almost exclusively upon the role of individual behaviour, neglecting broader political, social, economic and environmental factors. There is little guidance regarding the potential health benefits of non-medical, non-specific intervention. However, consideration of some of the probable resources and opportunities for health (see Appendix II) - adequate income, available social support, meaningful work, provision of play or recreation facilities - reveals, in most countries, large inequalities in their distribution. Changes in these broad indices of opportunity may prove useful process indicators for health promotion. Identification of more precise or appropriate indicators will depend upon achieving some consensus about the outcome - health - and upon the progress in research which aims to explain variations in its distribution. Evaluation of health promotion in terms of outcome will require, in the first place, an operational definition of health, leading to the specification of health goals for individual projects.

5.2 Factors influencing response to health promotion:

In the presence of more certain knowledge there is considerable experience from disease prevention projects, which directs attention to the complex and subtle issues demanding resolution for the application of effective interventions. It cannot be assumed, for example, that the knowledge or technical ability to attain a particular objective (e.g. immunization, control of hypertension) will be complemented by the interest, knowledge or values of relevant groups, whether government, medical profession, industry or general public. Like so much of the research and literature relevant to health promotion, most work on the assumptions underlying prevention and promotion activity comes from North America; although referred to below, its relevance to European society cannot be taken for granted.

Interest in the maintenance and promotion of health appears to be increasing, reflected in the expanding literature, services and entrepreneurial activity around the subject. It is linked to a growing interest in, and emphasis on, preventive medicine (Saward and Sorensen, 1978). Several studies in the United States point to a high level of demand for services oriented towards maintaining wellness (Pender and Pender, 1980) and a general perception that prevention is now a higher priority public concern (Clark and Barron, 1979). A review of several reports on this theme (Bauer, 1980) refers to evidence that over half of all American adults are much more concerned about preventive health than they were a few years previously, although the priority given to preventive over curative health services was much higher among business executives and union officials than among the general public. British data similarly report high demand for information about health (Pike, 1971; Cartwright and Anderson, 1981), and growing public interest in having a regular check-up, say every two years - from 64% of adults in 1964 to 78% in 1977 (Cartwright and Anderson, 1979).

It may be that much of the growing interest in prevention is specific to particular diseases - which would be compatible with current thinking in medicine about appropriate strategies for prevention (Breslow and Somers, 1977; Bayliss, 1981). Puska and colleagues (1981) report that between 1972 and 1977 a declining proportion of the population in Eastern Finland agreed with the statement: "Doctors can prevent most of the severe diseases" - the figure in 1977 was about two-fifths who agreed. It can also be seen that there are wide variations between people in the factors they identify as influences on their health. Only half of a sample of mothers in South Wales referred to daily lifestyle choices as relevant factors in a discussion of illness causation (Pill and Stott, 1982). Huber (1979) refers to a survey in the Federal Republic of Germany in 1977

in which only 38% of the population thought they needed to do something about their health, and only 6% thought they endangered their health through their own behaviour; this contrasts markedly with the reports of personal efforts to improve health in American surveys of the same time (Bauer, 1980). In one of these surveys, respondents listed both environmental and lifestyle factors perceived as threats to health: 59% mentioned industrial waste, 55% cigarettes, 55% crash diets, and 40% nuclear power plants. Public assessments of risks to health are tuned to the characteristics of particular circumstances (Brown and Green, 1981) but may be regarded as poor estimates of the probable health risks of different behaviours and conditions (Hallett, 1980). Effective efforts to promote health will depend at the very least upon good and relevant public knowledge about the determinants of health.

There is a large amount of evidence relating income and social class to use of both preventive (Cartwright and O'Brien, 1976; Blaxter, 1981) and promotive (Brotherston, 1976) health services. Other studies show that preventive services may be least effective in reaching those at highest risk (Kleinman and Kopstein, 1981, Ben-Sira, 1981) or with the greatest need. Considerable efforts have been made to explain such findings in terms of knowledge, health beliefs and attitudes. Middle-class people, it may be held, are more easily able to absorb new information. They may be more inclined to use the available information, not only because they have more resources, particularly money, but also because they are more likely to see the information as relevant to their needs, and they are more likely to believe in their ability to control their health - and therefore to believe in the value of efforts to protect or promote their future health. Blaxter (1981), in a major review of cycles of disadvantage, stated that: "Over time a way of life characterized by poverty induces social and psychological traits including a lower valuation of health. Preventive behaviour requires an orientation to the future, towards planning, and towards deferment of immediate gratification in the interests of long-term goals: feelings of hopelessness and inability to cope with a hostile environment may be relevant" (p. 154). Those people with the clearest concept of future benefits for present action, and with the clearest information about available services are more likely to make use of the services. Those people absorbed in coping with current pressures and demands, and without reserves of time, income or energy are least likely to engage in activities for the enhancement of personal well-being.

Many of the threads relating to health knowledge and attitudes have been drawn together in the Health Belief Model, expounded by Rosenstock (1969) and used in many studies designed to explain health actions - mainly preventive and compliance behaviour. The model has been developed particularly in the work of Becker (1974) and colleagues (1977). The model postulates that the likelihood of taking a health action is a function of the individual's predisposition to act (the "readiness" dimension) and other personal or environmental factors (the "modifying" dimension), which may enhance or impede this action. Most work has focused only on the "readiness" dimension in the context of behaviour to prevent or mitigate disease, not to promote health; and the main features of the model reflect this orientation. The key variables consider the individual's perception of susceptibility to the disease, beliefs about the severity of the threat, estimates of costs and benefits related to taking the health action, and the more recent incorporation of a measure of general health motivation. The model (and particularly the susceptibility and perceived benefits of action variables) has been employed relatively successfully in studies of screening for particular diseases, obtaining immunizations and compliance with medical regimens. However, the results are not consistent, even for behaviours such as screening (Ben-Sira and Padeh, 1978), and they appear variable for different groups, for children and adults (Radius et al., 1980) under different living conditions and using different research strategies: "In summary, after 20 years of research, the picture in regard to the causal connection between health beliefs and health behaviour is still cloudy, despite the relative abundance of correlational data in support of the Health Belief Model ... There thus remain a number of important questions about the validity and the generality of the Health Belief Model, both as a means of understanding health behaviour and as a tool for increasing the level of health behaviour in the population." (Weisenberg et al., 1980, p. 61-62). Research which has considered the link between health beliefs and the more complex behaviours associated with health promotion, such as exercise adoption (Lindsay-Reid and Osborn, 1980), and positive health practices (Harris and Guten, 1979), suggests that the variables in the model may be of relatively weak predictive value. There is a need to develop comparable variables to be incorporated in a model which goes beyond medically approved health behaviours to encompass a more positive conception of health, and to employ these variables in prospective studies concerned with the development of, and changes in, positive health behaviour.

The role of modifying variables such as education, availability of services, and environment, has largely been considered in studies other than those investigating health beliefs. However, in an American study investigating alternative explanations for the association between income and the use of preventive care, Rundall and Wheeler (1979) concluded that "although one's attitudes regarding health and illness, perhaps determined through a variety of social and cultural processes associated with one's economic condition, have some impact on one's use of preventive services, of greater importance are the explicit barriers present in the health care system, which tend to channel the poor into a provider network that does not encourage preventive care." (p. 405). Wan and Gray (1978), studying use of services for immunization and physical check-ups by preschool children in low-income urban areas, similarly point to the important role of access and availability of health services. Other research has identified positive relationships between preventive health behaviour and proximity to centres of medical care (Steele and McBroom, 1972), poor health status (Harris and Guten, 1979; Rundall and Wheeler, 1979), higher education of female head of household (Steele and McBroom, 1972), involvement in social networks (Langlie, 1977), and an energized family structure (Pratt, 1976). The point of referring to these studies of preventive health practices is only to illustrate the range of variables which might be relevant to adoption of positive health behaviours. As a social rather than medical activity, the resources and facilities for health promotion will go beyond the provision of health services and availability of screening technology. The factors influencing the development of promotive and preventive behaviours may be very different or opposite in effect. It is significant that Harris and Guten (1979) reported it unreasonable to generalize from findings about preventive behaviour to other health practices. They found that family income and education were related to performance of both health practices and preventive care, but in opposite directions: "Higher income and education levels are associated with more preventive care activity, but with fewer health practices" (p. 28).

5.3 Effectiveness and ethics of encouraging individual responsibility for health

In the case of health promotion, most notions appear to be attuned to a reduction in reliance upon health services and the acceptance of greater responsibility for health by the individual. However, habits of health care and attitudes to use of services are unlikely to change rapidly, particularly if "Years of publicity efforts to urge people to consider physicians as the experts responsible for health appear to have convinced many people of the attractiveness of making physicians responsible for the individual's health." (Kronenfeld, 1979, p. 266). Accepting this new orientation to health promotion and the increase in personal responsibility that it implies may again be more compatible with, and manageable in, the living conditions and world view of middle- rather than working-class people. The individual "lifestyle change" approach may increase disparity in health between rich and poor, or, at least, is unlikely to cause any narrowing of health differentials. Blaxter (1981) concludes that, "while the importance of health education ... cannot be ignored, it can nevertheless be suggested that the review has shown that this view of health as the individual's responsibility is unlikely to have much effect on persisting or cyclical health disadvantage" (p. 222).

Holtzman (1979) has suggested that an emphasis upon prevention through individual responsibility for lifestyle change will be less effective than other approaches, employing, for example, social and environmental strategies - a view reinforced in the Black Report on inequalities in health (DHSS, 1980), which stressed the importance of government action to legislate against health hazards. If adverse features of the social, environmental and economic system, not amenable to individual correction, are major determinants of health, then emphasizing personal responsibility and voluntary change in behaviour will be ineffective.

In addition to direct effects of the environment upon health, the scope for personal modification of behaviour depends upon the availability of resources from the environment, such as information and facilities, together with power to change factors which influence health. As such, the development of personal and community control of their health is likely to call for more active involvement of government and community institutions in health promotion: "... behaviour for all practical purposes is environmentally determined and while responsibility for health may be returned to the individual, the ultimate responsibility for creating a healthy environment, using that word in its broadest sense, rests fairly and squarely with central and local government. For each individual in his own case, a positive style (that is, adaptation to the environment) is the most effective way of changing his own health-related behaviour. A progressive health enhancement programme in any community will therefore place greatest emphasis on environmental change rather than on regulation of the individual" (McGann, 1980 p. 20). However, it appears that, to date, emphasis in public policy has been upon changes in individual behaviour rather than government or business lifestyles (Tsalikis, 1980; Labonté and Penfold, 1981). In both debate and practice, the individual and the environment have tended to be polarized, when a recognition of their interaction seems more appropriate: "the best way to improve health may be through behavioural and environmental improvements combined with the provision of care" (Kaprio, 1979, p. 10).

Stress upon the modification of individual lifestyles may equally be counterproductive if resources and opportunity for pursuit of desired behaviour are unequally distributed. Holtzman (1979) fears that "the doctrine of self-help may well signal a new era of Social Darwinism: those who cannot help themselves deserve their lot" (p. 33), and that those who do not behave in the approved manner may be devalued or vilified. Of the "health fiends" in Central Park, New York, Blandford (1981) has observed, "... it is not pride and self-esteem that the jogger exudes these days. It is contempt for those who are weaker. Thus, one no longer gives thanks for health and strength; one disdains those who are infirm or old for allowing these conditions to overtake them ... even more disquieting is the assumption that, somehow, muscle equals intelligence. Once there was brawn and there was brain. Now it is the stupid who grow fat and lax and unfit" (p. 12).

The emergence of an ideology of "victim-blaming" which places responsibility for health problems with the individual, neglecting the social determinants and constraints on healthy behaviour, has been documented by Crawford (1977). In a second article (1980), he examines some of the ethical issues which arise as a consequence of the new health consciousness pervading American culture, and the development of "healthism" as a general paradigm for good living. This prescription of approved personal behaviour and attitudes diminishes awareness of factors influencing health: "... the language of self-care, individual responsibility and holism obscures the power relations underlying the social production of disease and discontent" (Crawford 1980 p. 383). The "individual responsibility for health" approach may be guilty of simplistic and unfounded assumptions about the extent to which exposure to health risks is voluntary (Veatch, 1980) and control of health-promoting behaviour either available to individuals or effective in improving their health. Increasing individual responsibility for health depends upon increasing individual control over living conditions, provision of an environment in which healthy choices are the most rational, providing an environment conducive to active learning on the part of the individual and one in which other social groups complement and are supportive of personal activities.

From the perspective of health promotion there are always difficulties in identifying what those activities should be. There are obvious problems in deciding which values should be promoted, how such decisions should be taken, and how benefits or costs to individuals and community should be balanced. In principle, health promotion is based upon self-determination and control, which means respecting the rights of individuals to affirm their own values and interests and their right not to have those of others thrust upon them. Yet much that passes for "health promotion" is characterized by promotion of lifestyle change in a direction decided upon by experts. This raises many ethical issues relating freedom and justice to use of legislation, behaviour modification and persuasion techniques (Faden and Faden, 1978). Most of that which is described as health promotion appears directed to increasing coping capacity to deal with environmental demands, rather than responding to the interests of the individual. Law (1979) suggests that in creating the "responsible consumer", "more attention will have to be given to changing our existing institutions to meet the needs of the individual, rather than limiting the use of health promotion to "adapting" the individual to the system" (p. 8). As Crawford (1980) and others point out, it is not that the present message of health promotion is universally unpopular - almost everyone desires to be healthy rather than ill, and for substantial numbers of people, lifestyle change, self-help, and the adoption of new eating or exercising patterns are both feasible and rewarding. The idea of personal responsibility for health may also be good for business, creating a market for health promotive products. In most sectors of health promotion, whether diet and exercise, personality or sex life, there are a plethora of guidelines and gadgets, gurus and golden pathways to good health. Brailey (1980) has created reservations about this market explosion, however, suggesting that "the enthusiasm, claims, and, in some instances, avarice of these entrepreneurs is rapidly outstripping the slow, laboured and expensive research effort to establish results and their costs scientifically." (p. 55). In the "growth industry" of health promotion, the interests of the public, business, medical experts and government may not always be compatible.

6. In conclusion

In this overview it has only been possible to present a sketchy outline of the health promotion concept, its origins and use, and of some activities which might be taken to illustrate health promotion in practice. The development of health promotion is recent, but its growth has been rapid, particularly among social and community groups. Now "health promotion" has been taken up by health professionals and governments in several European countries, as a priority area for development. However, the rhetorical and political attractions of this concept have not so far been matched by the input of resources, support and guidelines for practice. The momentum

generated has not so far accumulated in any clear definition of underlying assumptions, philosophical bases or theoretical principles. The objectives remain unspecified - "improving health" merely begs the issue. The strategies or approaches to be employed - community participation, intersectoral collaboration, modification of underlying causes - appear sharper and more straightforward in their abstract formulations than in practice.

Finally, our knowledge of what is being done in health promotion in Europe remains slight, as does our understanding of the epidemiology of health which might inform the discussion of priorities in health promotion.

These considerations focus attention on some of the issues which must be tackled to develop appropriate strategies for promotion. First and foremost is the need for a critical debate to establish the assumptions and philosophy underlying the goals and methods of health promotion. More conceptual and theoretical work is necessary to develop an integrating framework which would allow some organizing and ordering of projects identified as "health promotion" and permit some prediction of the application and ramifications of the concept. The distinction between health promotion and disease prevention must be clarified, and some assessment of the feasibility and usefulness of this distinction in both principle and practice be made. At present, health promotion is diffused over too much ground, so that the range of issues which might be addressed appears endless. There is little information about experience in different social and cultural contexts of strategies to assess the need for and implementation of different health promotion programmes. Specification of priorities should be based on a knowledge of needs, acceptability and effectiveness of different methods for improving health, so that an agenda of relevant, attainable (and measurable) objectives can be drawn up. In developing programmes for health promotion there appears to be a lack of appreciation of the extent to which social, environmental and living conditions conducive to health form the basis from which individuals can develop their own potential to realize good health. Decisions about the personnel involved in these programmes will depend upon clarification of community and professional responsibilities, and the success of the programmes will require more effective strategies or organization for intersectorial collaboration and coordination of the diverse health promotion activities. Beyond technical skills and the provision of resources, successful health promotion will depend upon a sympathetic and supportive social environment in which health is highly valued, whether in the community, at work, or in government.

These observations were the starting point for the meeting of a small working group at WHO Copenhagen last year. A summary of the discussions and recommendations of this group is attached as Appendix III.

APPENDIX I

The survey letter

Preliminary thoughts for the 'Basic Study
of Health Promotion Practices and
Formal Programmes in the European Region'

As part of the Health Education unit's activities in the Regional Office for Europe of the World Health Organization, I am preparing an overview of health promotion activities in the Region. My first step has been to discover or devise a concept of health promotion which would allow me to delimit the field of health promotion activities. What follows are some initial thoughts leading towards a working definition of health promotion. They do not in any way represent confirmed WHO approaches to health promotion; any suggestions for modification or change would be very welcome.

The terms "health promotion" and "positive health" have become fashionable in health education, frequently used in rhetoric, but seldom considered precisely. Health promotion has been discussed as the context within which an activity takes place, as the emphasis of a particular programme, or as a positive approach within a more traditional risk reduction programme; it is seldom the explicit aim of the programme. I am interested in those programmes (whether in the field of health, welfare or community development) which have as their aim the promotion of health. I have thus chosen the following definition of health promotion: "any combination of health education and related organizational, political and economic interventions designed to facilitate behavioural and environmental adaptations that will improve or protect health."

This definition has several advantages, most clearly that it specifies programmes designed to improve or protect health and reflects a broad outlook which, at this stage, it seems advisable to take. However, the definition fails to recognize or make explicit the fact that promotion of health may be carried out by, as well as for, individuals and groups. I am particularly interested in the activities which the informal, the lay or non-professional sector engages in to improve or protect health.

The distinction between health promotion and certain disease prevention activities is blurred. To simplify matters I have decided to exclude from consideration programmes which have as their main purpose the reduction of risk factors for particular health problems. Similar, I am placing illness management and rehabilitation activities outside my concept of health promotion because they are promoted by the need to manage an existing problem.

Before attempting to categorize some activities which may maintain or improve health, I need a working definition of health. I have chosen to consider health as the extent to which an individual or group feels positively adjusted to themselves and their environment - recognizing here physical, social and mental components to adjustment. The relationship between the individual or group and their environment will be influenced on the one side by their resources affecting their ability to adjust, to master or cope with the environment, as well as the ability to change the environment to accommodate their needs or demands. On the other side, the "fit" of person and environment reflects the extent to which the environment facilitates or creates barriers to individual changes, and the extent to which the environment influences health regardless of individual behaviour. These considerations have led me to develop four categories of health promotion activities as follows:

1. Individual or group practices - those activities in which people engage to maintain or improve their health, and which are not motivated by the need to respond to a specific disease or health problem. These include traditional health maintenance and activities, e.g. physical exercise, jogging, sports; monitoring and moderating food and alcohol consumption; yoga, transcendental meditation, relaxation sessions; involvement in youth, social, arts and other societies; attendance at educational classes to learn about one's body and influences on health; these are the things that individuals do to "stay fit", "feel better", "prepare for life", "feel good". Additionally, individuals and, especially, groups, may seek to promote their health through participation in community activities designed to change the organization or provision of local facilities. for recreation, employment, social contact, arts, etc.; or groups involved in efforts to change the physical environment of noise, traffic, air pollution and so on.

2. Educational and training activities - these are the broad categories of self-care and health promotion programmes typically designed to increase the ability of people to make decisions regarding their health (and its maintenance) and to provide skills enabling people to implement these decisions. Such activities include formal programmes designed to increase knowledge of the relationship between health and behaviour, or health and environment, or health and the provision of social, medical or welfare services; training in life skills, such as decision-making, participation and social interaction; training to deal with predictable life transitions, such as leaving school or entering work, retirement, parenthood; education for recreation, creative leisure, sport or physical fitness; training in yoga and relaxation.

3. Changes in the environment designed to facilitate the promotion of health by individuals or groups - these might include the availability or pricing of foodstuffs; provision of cycle paths, jogging paths, play areas for children; provision of buildings where people can meet or play or walk; improving access to medical, social or welfare services; financial support for certain designated activities, e.g. promotion of community participation in the shaping of their health and related services.

4. Changes in the environment designed to be of direct benefit to the public. These changes are frequently based on legislation, for instance, legislation that prohibits smoking in public places, reduces permitted noise levels, changes the code of advertising standards, increases the quality of housing and work conditions, finances aesthetic improvements; legislation in the areas of marriage, sex, child care - a combination of proscribing and enabling legislation.

Activities in categories 2, 3, and 4 may be carried out by governments, local authorities, voluntary organizations, community groups or other informal associations; they may have as their targets the young or the elderly, the newly-married or those about to retire, company executives or those living in difficult, impoverished conditions; the activities may be carried out at home, at work, at school, in a social centre or elsewhere; health promotion may be the focus of an activity or only part of a more comprehensive development programme.

There is every chance that the concept of health promotion applied here is too wide-ranging and unwieldy. However, in this preliminary overview, there is clearly a need to document as broadly as possible activities in all four groups (and especially the first, about which so little information appears to exist). In the context of the activities referred to above, the only criterion for recognition as a "health promotion" activity is that the explicit goal of the activity is to improve or maintain health. The activities listed are intended as examples, not as a checklist. Programmes will develop and emphasize different health promotion strategies, and alternative concepts of health or health promotion may lead to consideration of other activities. It would be most helpful to receive details of health promotion approaches, projects or programmes.

APPENDIX II

Towards an epidemiology of health

The Concept of Health

A variety of conceptualizations of health exist, evidenced in the statements of medical professionals, academics, policy makers, politicians and the lay public. These concepts differ between and within societies and change over time. The concept employed has vital implications for assessment of the causes of health, for the establishment of health needs and priorities, and for designating technological, professional, social, cultural, economic or environmental resources appropriate for the promotion of health. Some concepts of health are considered only briefly here, since comprehensive reviews are available elsewhere (Stacey, 1977; Svensson, 1980).

The concepts dealt with below are those which appear most relevant for health promotion. They all focus on individual health rather than looking at the health of the community, society or social system. As concepts of individual health, they are not statements about the factors which produce health, or about the relative importance of the individual and his social, physical or economic environment. Nevertheless, the different concepts point to different foci of responsibility and action for health promotion.

It is by no means straightforward to distinguish the assumptions or parameters of different concepts or, therefore, to categorize alternative definitions. However, major dimensions around which concepts vary are: health considered as an outcome or product, as a potential or capacity, as a process; health as something experienced by individuals or identified by outside observors, particularly clinicians; health as a fixed state or dynamic relationship; and health as an attribute of one element of the individual, such as physical fitness, or as a characteristic of the whole person, representing social, spiritual, emotional and physical aspects.

Product: The traditional medical orientation to health is bound up with concepts of disease, viewing health as a condition in which there are no signs or symptoms of disease. This narrow and negative concept of health-by-exclusion is at the opposite pole to the all-embracing, ideal-type definitions such as that of WHO: "Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity." It is hard to cavil at the concern for the person "as a whole", the positive orientation and the affirmation that health cannot be reduced to the absence of disease. However, the definition is commonly described as utopian (Dubos, 1968), Panglossian optimism (Antonovsky, 1979), unattainable as a perfect state (which would be unbearable) and irrelevant: "The springtime euphoria of such a statement of positive health seems to bear little relationship to the nature of our journey from the cradle to the grave" (McCormick, 1979, p. 19). A modest amendment to the definition which would remove the notion of health as an ideal state would be to remove the imperative "complete" and allow that health, like illness, may be of degree (Terris, 1975). In its breadth of coverage, it becomes difficult to establish which attractive, enjoyable or positive aspects of life are not contained in the notion of health. How can health be distinguished from happiness or the quality of life? "This bottomless conceptual pit makes it impossible in any practical way to specify the limits of the health enterprise, that is, to distinguish what is a practical, or ethical, or cultural problem from what is a health problem. ... If anything and everything from the state of the prisons, the schools and economy to the anxieties invoked by life can be called a health problem there is no end to the resources that can be expended in the name of medicine to cope with those unpleasantries." (Callahan, 1977, p. 26). The equation of health improvement with medical intervention and responsibility, implying the greater "medicalization of life", is a recurring theme of commentaries on the WHO definition. More fundamental questions are posed by the WHO definition about specifying and identifying the outcome of efforts to improve health. Which values, attributes or relationships constitute (complete) well-being? And how do the values associated with good health differ over time, between societies and between different groups within the same society? The issues linked to conceiving of health in terms of emotional well-being are discussed by Baelz (1979): " ... we are at once involved in value judgements concerning what makes human life really human, what is to count as human 'flourishing'. Is it 'healthier' to live from day to day without bothering about the past or the future, to live, that is, a carefree existence; or to have a developed sense of responsibility for one's actions in the past and one's opportunities for the future at the cost of considerable anxiety and strain? If human loves are the essential ingredient of human flourishing, can man expect a carefree existence ... to pass from health to well-being to flourishing to love to happiness to joy is to introduce at each new stage new ideas and new considerations" (p24). We may ask how and by whom such judgements about values and states compatible with complete well-being can be made.

Potential: Rather than attempting to define health as a particular abstract good or specify outcomes, several authors consider health as a capacity, potential or ability to achieve preferred goals or perform certain functions. In a revision of the ideal state formulation, Dubos (1968) considered health as, "a modus vivendi enabling imperfect men to achieve a rewarding and not too painful existence while they cope with an imperfect world." Thus the potential for health will depend upon man's ability to cope with, or respond adaptively to, environmental challenges, as well as his ability to realize personal goals and aspirations. The healthy person is one in harmony with, or adapted to, his physical, mental and social skills or ambitions, as well as to environmental conditions - and able to re-establish this harmony when circumstances change. Berg (1975) discusses health as the capacity to function effectively in the environment, such that the person realizes his potential for achievement. The concept of health as dependent upon the ability to adapt to change is common to several writers from different perspectives, e.g. McCormick, 1979: Health is the ability to live autonomously: health is successful coping"; Green, 1980 "..the ability of a system (a cell, an organ, an individual, a family, or a community) to adapt its equilibrium in response to change"; and Parsons (quoted in Gerhardt, 1980) defining health as teleonomic capacity: "the capacity to maintain a favourable, self-regulated state that is a prerequisite of the effective performance of an indefinitely wide range of functions both within the system and in relation to its environments". These functions refer largely to those roles and tasks for which individuals have been socialised, and for which there are generally well-established norms and expectations, e.g. father, employee, wife. In these concepts of health as a potential, health is not an end in itself, but a means to an end, whether this is the performance of activities usual for a social role or the realization of personal aspirations. Responding successfully to the challenge of changes in self or the environment appears to be a principal characteristic of healthy people in this formulation. However, establishing appropriate conditions for the achievement of valued goals may involve changes in either the individual or his social, physical or economic environment. "Health is the milieu (human and environmental) which enables people individually and socially to grow towards fullness of life." (Wilson 1975, p. 80).

Process: The themes of growth and development are central to a further group of health concepts which emphasize health as an ever-changing, dynamic phenomenon or process. In a simple morphological sense this may relate health to optimum physical growth and body development. The health process may be cumulative, in relation, for example, to learning and development (Bruhn et al, 1977), or cyclical, in phases of creation and destruction. The point appears to be that health is a continuous pattern of change occurring over the lifetime in all dimensions of the individual. An alternative conceptualization of health as process emphasises health as a means through which people work towards chosen ends. Hettler (Hawkins, 1981, personal communication) defines wellness as, "An active process through which the individual becomes aware of, and makes choices toward, a more successful existence. These choices are greatly influenced by one's own self-concept and the parameters of one's culture and environment. Each individual develops a unique lifestyle which changes daily in the reflection of their intellectual, emotional, physical, social, occupational and spiritual dimensions." This view of health as an active process appears to underlie much of the current thinking in new paradigms of health such as the holistic approach, which refers to the continuous interaction of mind, body and environment. In pointing to the primary contribution of mind and attitude, health is discussed as an active process "issuing from inner harmony or disharmony, profoundly affected by our states of consciousness, our ability or inability to flow with experience. This recognition carries with it implicit responsibility and opportunity. If we are participating, however unconsciously in the process of disease, we can choose health instead". (Ferguson 1981, p.257). Again the theme of meeting environmental challenges or stress is mentioned. However, the scope for successfully responding to change or new environmental stimuli and for having effective choices is related to the distribution of some resources and opportunities beyond the mind, e.g. employment, income, social networks.

In summary, there is a diversity of concepts of health, held by medical professionals, academics and politicians. These concepts are not necessarily consistent with one another, although they exist together in the same society at the same time. The differences between the concepts are not always clear, nor are these orientations to health always made explicit by professionals in their work. However, it is apparent that, in medicine, at the present time in Europe, the negative concept of health as the absence of disease dominates decision-making, planning and the organization of services. Medicine is primarily concerned with the cure and alleviation of specific diseases rather than the promotion of health in a general or positive sense. (Further implications of the medical model are discussed by Illsley, 1977). It would be surprising if contacts with medical practitioners and the health services were not a significant influence upon the development of the concepts of health by the lay public.

Lay concepts of health:

Considerably more time and research have been devoted to the elucidation of lay concepts of illness and response to the signs and symptoms of disease than to concepts of health. One reason for this may be that illness, pain and discomfort are absorbing concerns to people, whereas, in the absence of these problems, health may be taken for granted and of little interest: "A healthy body functions to the full extent of its capacities, free from limitations of pain or illness. It does not demand one's conscious attention; it allows consciousness to focus fully on the external world" (Idler, 1979, p.726). Nevertheless, health as absence of disease is only one of several lay perspectives on health. The few studies of lay health concepts point to functional capacity or potential for health and to well-being or positive health as other relevant concepts.

Stott and Pill (1980) conducted fairly unstructured interviews with mothers of families with small children, registered with a practice in South Wales. In response to questions such as "What does 'being healthy' mean to you?", "Would you think of yourself as basically a healthy person?", three main categories of health concept were uncovered. Firstly, health as absence of illness, e.g. "Yes - pretty good (health). I only get two illnesses a year, that's flu at Christmas and hay-fever at this time of the year" (p 39). This "healthy except for ... (some illness)" type of response has also been found among disadvantaged Aberdeen women, and Illsley (1980) suggests that this points to a concept of basic or underlying health broken by specific illnesses. Health as absence of illness was likewise identified by Herzlich (1973) as a common conception held by a sample of Parisians: "Health is strictly speaking not something positive, it's simply not being ill" (p. 56).

The second category of Stott and Pill (1980) is health as functional capacity, that is, being able to do what one has to do, being able to function as expected, e.g. ("What does being healthy mean to you then?") - "Feeling great. I could cope with anything. Not only that, I think with a family you can't afford to be ill, you know what I mean? ... But, of course, if you're very ill you'd have to give up, but I never have - being healthy you can sail through anything." (p. 40). Being healthy and therefore able to cope has some affinity with a concept of Herzlich's Parisians, of health as a reserve, or source of resistance to disease, e.g. "I've had a whole heap of worries, you can just about cope with them when you have a good reserve of health, I mean healthy tissue and healthy bones." (p. 57-8). In general, health as the capacity to function breaks the link between health and disease or the suffering of occasional disorders. The ability to maintain normal or expected activity is the key, so that health is a "master status" (Locker 1981) the estimation of which is independent of transient illnesses. Even apparently significant disorders may seem unexceptional, particularly when expectations change over the life cycle. Thus a daughter reported that her recently deceased mother was: "an active woman before this with no previous restriction apart from general old age, deafness, loss of sight in one eye and loss of memory. The doctor said at the inquest she was a very fit woman for her age" (Cartwright et al, 1973, p. 41).

It is clear that the presence of illness or symptoms is a powerful influence on self-assessments of health (Garrity et al, 1978; Ferraro, 1980), but that symptoms are compatible with self-estimation of health as excellent (Dunnell and Cartwright, 1972). Little is known about factors influencing self-estimates of health, but expectations about tasks and activities appropriate to lifestyle and aspirations for the future are likely to play some part. (Taylor, 1981).

The concept of health as a positive condition of physical and mental well-being was expressed by over half of the mothers in the South Wales study (Stott and Pill, 1981) in terms such as "Being fresh and sort of bubbly, enthusiastic, sort of cheerful" (p. 40). There was evidence that mothers who recognised the role of lifestyle factors (e.g. diet, exercise, stress, relationships) in determining health were more likely to have some concept of health in a positive sense, and to view health as a dynamic relationship between the individual and her environment, susceptible to a variety of influences, some of which are under individual control. Herzlich (1973) identified a concept of health as "equilibrium" as that most common among her sample of Parisians. This equilibrium referred to health in terms of well-being and abundance of potential e.g., "when the body functions like a well-oiled machine, without having to be looked after ... and there's also having sparkling eyes, a good colour, to feel at ease when you meet up with friends, and not to be at all on edge" ... "When I am enjoying good health, I feel well, there's a sense of equilibrium when I feel that everything is going well, and difficulties appear quite insignificant" (p. 58). Significantly, Illsley (1980) reports the lack of a concept of positive health among the women in Aberdeen from disadvantaged backgrounds. This was linked to some fatalism about the determinants of health and antipathy to preventive health measures.

Positive Health: In a search of the literature this has proved to be an elusive concept, which tends to be employed in opposition to concepts of health limited to the absence of disease or distress (cf. Amador, 1975). It comes under several guises as well-being, wellness, equilibrium and good health. In one sense it appears to refer to a kind of super-health involving smooth, efficient and sensitive functioning of the human body. It is located in the physiology and functioning of the body and is revealed in terms like fitness, alertness, acuity of vision and hearing. Beyond this is functioning with abundant zest and vitality, with reserves of energy (Terris, 1975; Breslow, 1972). There is, however, another dimension of positive health which is linked more clearly to emotional and social involvement or satisfaction, and may be expressed in basic terms such as contentment, comfort, confidence or creativity. In this sense, health is more than successful adaptation by man to environmental demands; it involves the capacity to communicate and express oneself, to create, to change oneself and one's environment in a positive way, and also to accommodate to the pain and problems of life in a peaceful way instead of protecting oneself aggressively. The healthy person is one able to realise his potential for growth and fulfillment, for personal enlargement and freedom. Specifically, positive health is frequently described in terms of social involvement, rather than personal isolation. In this sense, positive health involves enrichment of others as well as self. Thirty years ago a WHO Expert Committee offered this conception of mental health: "the capacity of an individual to form harmonious relations with others, and to participate in or contribute constructively to changes in his social and physical environment" (quoted in Kostrzewski, 1979). The opportunity and ability to join in, and contribute to, the local environment and community may be distinguished as basic characteristics of positive health (DHSS, 1980; Duval, 1977). It is unfortunate, however, that so little has been done to specify, or even conceptualize the dimensions of positive health. This may be because interest in "real health" is relatively recent and has not engaged the interest of people in medicine, or because "positive health" is basically not an issue of relevance to medicine, being rather the province of those interested in psychology, human development and social relations. The lack of a clear concept of positive health, its elements and their dimensions, creates a rather serious barrier to our understanding of its determinants.

Berg (1975) suggests that it will not be possible or, at least, easy to reduce positive health to a limited set of issues to be tackled consecutively. Instead, the study of health will demand an orientation to whole human beings - mind, body, environment together. It may be complex in such circumstances to disentangle health from other elements of the quality of life. But a research effort to identify health and factors involved in its maintenance and development is urgently required, particularly when " ... we do not know very much about health; what it is, what its status is, and in which direction the development is going". (Berg, 1975 p. 20).

The origins of health

In attempting to bring together material on the promotion of health, the lack of an adequate concept of positive health, or any consensus about the general concept of health, creates a problem in deciding which material might be relevant and what the limits of the literature review might be. In an effort to clarify the concept, and provide some reference point for data collection, I have concentrated attention on what might be called the "ecological model" of health. Following Dubos (1971), "Health and disease are the expressions of the relative degrees of success or failure experienced by man as he tries to respond adaptively to environmental challenges and also to the inner demands created in him by traditions and aspirations." (p.220). In a sense then, health is a state of adjustment or adaptation or "fit" between person and environment (French et al., 1974), but the relevant environments are those both internal and external to the individual. One aspect of health is therefore the ability to cope with changes in the external environment, to regulate the changes and maintain stability. This may be achieved through personal coping skills and accommodation, through the intervention of some institution or agency mediating between person and environment, e.g., government, employer, medical care, neighbours; or through change in the environment. Goldsmith (1980) has suggested that: "True adaptation must refer to change that combats discontinuities by creating the conditions that must reduce their incidence rather than neutralise them however impressively ... change, in fact, that tends towards stability rather than accommodate instability." (p. 238). Therefore a healthy person is one able to meet the usual demands of his environment, whether these are the performance of particular social and economic roles, or the ability to travel to work; and he is able to cope with or change excessive demands or stresses.

On the other side, good health means the ability to realize personal goals and aspirations. This requires stimulation and a social environment in which goals and aspirations can be developed, and consequently an environment which facilitates, rather than creates barriers to, personal growth and development. On this side of the equation are also the more basic demands for an environment which meets housing, security, employment and other essential needs.

The degree of adjustment between person and environment will reflect the balance of these needs and demands at a point in time, but the level of adjustment will change to reflect the dynamic relationship between individual and environment. The strength of this ecological model is not perhaps that it is adequate conceptually, but that it incorporates clearly factors relevant to the production of health; it is a dynamic model; the level of health or adjustment can be positive; and it emphasises the relativity of any health concept since it is concerned with personal goals, capacities and resources, in the context of a particular social environment with associated values and expectations, within a particular culture and at a specific point of time in terms of the development of knowledge, technology and economy. Finally, such a model is holistic in orientation, dealing with physical, social, economic (and spiritual) aspects of both the individual's health and the environment. This appears sensible if only because the relationship between change along one dimension and consequent change in other aspects of health is not constant e.g., moving a disabled person into a residential home may improve physical health but cause a breakdown of social relations.

Identifying healthy people: It is not a strength of the ecological model, or of any other positive concept of health that it directs our attention to any simple measure for categorizing the health of individuals. As many researchers are aware, it is very much easier to record and provide some measure of departure from health than to develop criteria and indices for healthy functioning or the good life. Most research into health has been carried out using routinely collected data on morbidity and mortality, and, to a lesser extent, statistics on sickness absence and use of services. These probably tell us something about disease, and this is obviously of vital importance, but using most of the concepts of health discussed above, such data may not even be adequate indicators of poor health. In this context, healthy people are the non-users of health care (Anderson, 1977) or those who do not report or for whom no illnesses are reported. Some of the inadequacies of these data, including the various factors influencing use of health services and the levels of unreported or unrecognized illness are discussed in Doyal, 1979. These traditional indicators are oriented to the curative medical services and may be useful in the planning, organization and evaluation of these services (e.g. Holland et al., 1979), or they may be fairly insensitive to changes in medical care (Brook et al., 1977).

Sociomedical health indicators have been developed to enlarge our understanding of the experience of health and illness, and to provide measures more sensitive to the outcome of medical care. They distinguish the different social, economic and physical aspects of health, but are designed and employed almost solely to detail the consequences of ill-health. (Siegmann and Elinson, 1977). Health status may be based on the subjective evaluation of respondents (e.g. Hunt et al., 1981) or based on a system for placing values on different health states (Patrick, 1976; Sintonen, 1981). The value of particular degrees of functioning or activity has not been established in the context of positive health.

Measures of adjustment would seem appropriate indicators of good health, considering the ecological model. A promising departure in this respect appears to be Linn's "Social Dysfunction Rating Scale" (1969), which is a measure of the individual's relationship to his environment, his ability to cope with the environment and his response in terms of satisfaction, self-regard and orientation to the future. "Effective functioning suggests equilibrium within persons and in their interaction with the environment, involving adequate and integrated fulfilment of needs related to goals, and how they see themselves achieving these goals. Dysfunction, on the other hand, implies discontentment and unhappiness, accompanied by negative self-regard." (Linn, 1979). It is with the negative implications that the scale is most concerned. A host of other measures deal in some respects with the positive implications of adjustment, both in distinct spheres of life such as work and marriage, and overall. These are the measures of well-being (Andrews and Witney, 1976); quality of life (Campbell et al., 1976; Krupinski, 1980); life satisfaction (Neugarten 1961) and happiness (Bradburn, 1969). It is not, however, always clear how the different measurements relate to particular conceptual formulations, or what their relationship is to each other (George, 1979; Costa and McCrae, 1980), nor is it clear how health is related to the quality of life. Krupinski (1980) reports that high scores on one element of the quality of life measure, i.e. fulfillment in different aspects of life - work, family, recreation, material security, personal relations, was markedly related to lower levels of psychiatric disorder. Since it is not impossible to think of fulfillment in life as, in itself, a measure of positive health, there is clearly a need for some conceptual discrimination between the concepts of quality of life and positive health. If there appears to be no distinction, then the coverage of health promotion will, indeed, be wide.

There have been few attempts to measure health as a continuum on which there are points beyond absence of symptoms or illnesses. Exceptions are the measure of Sackett and colleagues (1977), which identifies good or even excellent functioning in social, emotional and physical respects; and the health measure used in the Alameda County study (Breslow, 1972; Belloc et al., 1971).

Physical, mental and social well-being were rated from low to high, e.g. the categories for physical health were: severe disability; less severe disability; presence of chronic conditions; symptomatics; no complaints; low to medium energy; and high energy. The mental health measure similarly went from "depressed or very unhappy" to "on top of the world". Social health was rated according to the degree to which the individual was a functioning member of society, using employability, marital satisfaction, sociability and community involvement as indicators. The measures do not appear to have been employed in other community surveys.

In the absence of adequate, available or appealing outcome measures of health, it has been suggested that multiphasic screening might be employed to assess reserves of health in individuals (Breslow, 1972). On this basis, Sebag (1979) has developed an "Anamnestic Health Index" for the diagnosis of health. An alternative approach might be to assess individuals at-risk for health or with potential for health. This would involve the identification of those conditions in which people will be more or less likely to develop health, and the monitoring of changes in these conditions. However, research into those circumstances which produce, provide the opportunity for or make people susceptible to, health has been neglected. Brown (1981), in a review of the sociological literature, found that less than 5% of reports were concerned with health in the sense of absence of disease. Information on the health maintenance practices of either lay people or professionals was almost absent. "An investigator rarely diagnoses symptoms of wellness and goes on to study the social and environmental relationships associated with wellness with as great an attention as he gives to individuals who become ill" (p. 196) Consequently, we are much better acquainted with factors influencing the development of health problems than we are with those involved in the development of health. However, the former research provides some guide to those factors relevant for the protection and maintenance of health, and for the ability to cope with the demands of the environment.

Identifying factors conducive to health

McKeown (1976) concluded his review of factors influencing mortality by stating that "...the requirements for health can be stated simply. Those fortunate enough to be born free of significant congenital disease or disability will remain well if three basic needs are met: they must be adequately fed; they must be protected from a wide range of hazards in the environment; and they must not depart radically from the pattern of personal behaviour under which man evolved, for example by smoking, overeating or sedentary living .... health depends primarily on the control of environmental influences, including those which the individual makes for himself by his behaviour" (p. 100). While this appears to be accurately reflected in data on the relationship between occupation, social class, smoking and mortality rates, it is nevertheless also clear that exposure to particular environmental circumstances or living conditions does not inexorably lead to the development of disease symptoms. The identification of factors which make certain individuals more susceptible to disease or protect them from developing disease has been discussed in recent reviews (Najman, 1980; Shuval, 1981), though the recognition of important variations in response to similar environmental demands and life changes was made much earlier (e.g. Hinkle et al., 1958). Without attempting to do justice to comprehensive work on vulnerability (e.g. Hinkle and Loring, 1977; Antonovsky, 1979), which includes consideration of genetic and biochemical differences, the following comments are limited to a consideration of some personal and social factors which appear relevant for the maintenance of health.

The influence of the environment on health appears to be mediated firstly by the meaning that a particular situation has for an individual. This will be so whether the situation is evaluated as positive or negative. In the case where the evaluation or appraisal is negative and the situation perceived as discomforting, harmful or threatening, the individual will need to mobilize resources to change the situation or its meaning in order to restore or maintain health. This process, which occurs in the presence of stress, is known as coping - "efforts, both action-oriented and intrapsychic to manage environmental and internal demands, and conflicts among them, which tax or exceed a person's resources" (Lazarus and Launier, 1978). The coping mechanisms may be personal (including physiological and personality traits, knowledge, money and coping skills) or social (including religion, cultural values, formal institutions and social networks). The impact of similar stresses appears to vary between social groups. In Kessler's (1979) analysis differential impact was more important than differential exposure to stressful conditions in explaining variations in self-reported distress by sex, social class and marital status. Part of the explanation for this differential impact may be due to differences in the distribution of coping skills. Pearlin and Schooler (1979) report that men, those with higher income and those with more education were more likely to use efficacious coping mechanisms. This appears to be related, in part, to personality characteristics such as high self-esteem and the sense that the person is in control of the forces impinging upon him.

The role of personality in the maintenance of health and life has been documented in other research. Differences in personality characteristics in youth were significantly related to later development of, or premature death from, mental illness, suicide, malignant tumour, coronary occlusion and hypertension in one study (Thomas, 1976). In a comparison of sick and rarely sick individuals (Burchfield et al., 1981), the latter appeared to have more happy marriages, to be stable and moderate in both emotions and habits and to have an optimistic attitude to life. They were much less likely to "worry a lot" or feel "uptight often". Although the influence of personality on health was not great (accounting for less than 20% of the total variance), these findings were similar to those of Valiant (1979) in a study of over 200 men followed for over four decades. He concluded that "positive mental health significantly retards irreversible midlife decline in physical health" (p. 1253). This finding remained after controlling for the effects on health of alcohol, tobacco use, obesity and longevity of ancestors. Although these studies are not without critics, particularly in regard to methods (e.g. Eisenberg, 1979), the idea that personality plays a significant role in the development of health has taken some hold, among for example the advocates for holistic health: "You can't deliver holistic health", one practitioner said. "It originates in an attitude; an acceptance of life's uncertainties, a willingness to accept responsibility for habits, a way of perceiving and dealing with stress, more satisfying human relationships, a sense of purpose" (Ferguson, 1981). But tracing our steps backwards we need to ask how this personality type associated with effective coping develops, and why these attitudes to self and life are distributed unevenly between sex, income and education groups. There is a dearth of information about these questions, but an indication comes from Caplan (1964): "...there appears to be validity to the assumptions that adequate food intake, proper housing and opportunity for sensory stimulation and recreation are conducive to mental health, and that their lack favours increased vulnerability to mental disorders" (p. 58).

The methods employed to measure mental health may be fewer in number than those developed in recent years to operationalize the concept of social support, and to identify the characteristics of social networks relevant to health (Gottlieb 1981). Much of this research has been stimulated by observations on the role of social support as an important moderator of stress (Cobb, 1976; Cassel 1976). The contribution of social ties, work and family relationships and close, intimate bonds to the protection of health has been evidenced in subsequent research (Hamburg and Killilea, 1979; Berkman and Syme, 1979; Brown and Harris, 1978). The mechanisms through which social support increases resistance to disease and the elements or characteristics of social networks which are most relevant to health in different conditions have not been clearly established. However, "It is now agreed that networks are essential elements of social life: they lubricate the hard heavy and complex machinery of formal social structures by allowing individuals a certain degree of security, a sense of belonging and of personal value ... and a recourse to pathways leading to help in crisis situations...The link between networks and primary prevention (of mental ill-health) has been documented by many authors." (Dubreuil and Wittkower, 1981, p. 102).

Informal social networks contribute to health in other respects as factors influencing the etiology, course and recovery from disease (Kaplan et al, 1977) and through their impact on the development of preventive and other forms of health behaviour (Langlie, 1977; Pratt, 1976). The social environment appears more directly related to the experience of pleasurable experiences in life and to consequent expressions of happiness: "... positive affect appears to be related to a series of factors concerning the degree to which an individual is involved in the environment around him, social contact, and active interest in the world. These factors include such things as the degree of social participation, which is reflected in organizational membership, number of friends, and frequency of interaction with friends and relatives, the degree of sociability and companionship with one's spouse, and exposures to life situations that introduce a degree of variability into one's life experiences" (Bradburn, 1968, p. 12). The same author notes that involvement in a variety of environments, membership of voluntary organizations and degree of social participation are related to socioeconomic status; and reports of positive affect increased with both income and education. This is not surprising when most of us enjoy opportunities for social contact and recreation, but have little pleasure in limited solitary activity.

The argument for more attention to the reinforcement of social networks and the provision of opportunity for social involvement is concisely put in a document to the Twenty-Seventh World Health Assembly of WHO: "We need not be dependent and look only on the gloomy side; the social environment can also inprove health, add to the quality of life, and provide opportunities for man to achieve a sense of fulfilment. Customs and traditions favouring health must be preserved. Beneficial social behaviour, such as community participation, should be restored where it has disappeared owing to social changes ... In many countries we still have to understand that, if standards of living are raised, better planned housing provided, and more attention paid to education and the organization of activities to cater for people's hours of leisure, it will be a significant contribution to human contentment and happiness" (Meyer and Sainsbury, 1975).

In summary, there is little information about factors which maintain or improve health, as opposed to those which precipitate or predispose to disease. In our present state of knowledge, the identification of factors which generate potential for health is both a complicated and a clumsy exercise, with little predictive power. Individual attributes and the characteristics of the environment, including political and cultural values, no doubt play a part, but the determination of those forces which are most significant is a question for research. The impact of different factors will vary, depending upon which aspects of health are being considered. The lack of consensus about the concept of health, particularly with regard to positive health is a barrier to the advancement of knowledge. In discussing some factors which might be relevant to the development of process indicators for health promotion, the focus has been narrow, but also superficial and relatively uncritical. Genetics and biology have been neglected, partly because of a lack of imaginative intervention strategies relevant to health promotion. Little has been said about aspects of lifestyle such as diet and exercise, though their contribution to the maintenance of health appears important (e.g. Terris 1975; Morris et al, 1980). Equally the physical and cultural environment, and the organization of society at local and national levels as determinants of health (Lerner, 1977) have not been considered, nor has there been any discussion of the positive effects of employment on health (Nathanson, 1980; Brown and Harris, 1978). Information about conditions which contribute to positive health may be accumulating. At present, the effort appears to be in the direction of consolidating evidence on the health-damaging effects of environment, living conditions and way of life. The relevance of this knowledge for health promotion will depend upon the concept of health employed.

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION
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BUREAU RÉGIONAL DE L'EUROPE

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

Working Group on the Concepts and Principles of Health Promotion

Copenhagen, 26-28 November 1981

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SUMMARY REPORT

Introduction

The seven temporary advisers who attended this meeting reflected a range of expertise: in housing, government, health education, social sciences, community medicine and nutrition.

Since the development of health promotion differs among regions in Europe, both in the pace of its growth and in the selection of priorities, an attempt was made to reflect this geographical variation in the composition of participants at the meeting.

Topics

The main purpose of the Working Group was to discuss and review the content and implications of a study on health promotion in Europe. This study drew attention to the lack of consensus in Europe on the meaning and scope of health promotion; it also illustrated difficulties in identifying in principle, and more so in practice, a distinct health promotion approach. The commentary and suggestions of the Working Group are being used to revise the study for publication.

The Group also considered guidelines for the further development of health promotion activities in the Regional Office. The participants reviewed the medium-term programme on health promotion for 1984-89, made comments about the form a "European health tour" might take, and were invited to make suggestions for the further contribution of the Office to health promotion in Europe.

Discussion

Each of the participants had prepared a background paper with views and observations on health promotion in Europe and several main themes emerged.

(1) The movement for health promotion, though new, is recognizable in many European countries, and is accelerating in its development.

(2) The growth of health promotion has been built on public rather than medical-professional interest. It is linked to a growing interest among the general public in positive health, in personal growth, and in community development.

(3) Because of the traditional orientation of the medical profession towards disease prevention, its contribution to health promotion is likely to be limited.

(4) There is no sharp distinction conceptually, and even less so in practice between disease prevention and health promotion. In general overlaps exist among activities directed at care/cure/prevention/promotion/quality of life. As such it is difficult to pursue a limited definition of health promotion which excludes disease prevention.

(5) There is a danger that the movement for health promotion may be dominated, rather than supported, by commercial and professional interests, with detrimental effects.

(6) Health promotion must take into account the interaction of individuals and the community, and variations in lifestyle and environment.

Several other areas related to the general notion of health promotion were discussed.

Definition

In the present stage of development it would probably be unproductive to define the concept of health promotion narrowly, although it was clear that some element of positive health was critical to describing activities in terms of health promotion.

Scope

An open definition of health promotion makes it administratively and scientifically difficult to delimit the field; virtually any issue taken up by a voluntary or community organization for the benefit of the community could come under the rubric of health promotion.

Role of WHO

Since appealing and acceptable health promotion activities will vary between countries it would be inappropriate for WHO or any international organization to define or support particular forms of health promotion to the exclusion of others. WHO could however devise guidelines for policies which would help people to develop their health.

A supportive environment

The improvement of health is intimately bound up with developments in other sectors such as the economy, transport and law. It is a priority therefore that health should be on the agenda of decision-makers and politicians in other sectors. "Healthy citizens" should be seen as a resource and a priority in other sectors. Health should also be considered in relation to environmental conditions, such as building density, travel to work, open space and opportunities for employment.

Community

Successful health promotion must be founded mainly on interest, initiative and involvement from local communities. Local people should identify problems, develop priorities and strategies for action, and implement change. Although this community development approach to health could have its limitations, there are examples of projects which have involved local opinion leaders and the community successfully, such as the North Karelia Project. The role of experts would be to enable communities to accomplish their chosen tasks.

Information

The availability of reliable and relevant information presented in a straightforward way is vital for changing lifestyles or living conditions to make them more conducive to health. Participants pointed to inadequacies in the quality of health information and in its presentation. On the other hand, there were illustrations from several countries of projects which had effectively increased access to information, e.g. in Italy, the "150 hours" programme of adult education during paid work.

Focus of health promotion

There is increasing awareness that specific programmes should be developed to meet the needs of different social groups and particularly target groups such as women with children, who play a central role in the development of their family's health, and disadvantaged groups.

Value of health promotion

Support for programmes in prevention has traditionally been grander in rhetoric than in reality. If promotion is to avoid following the same path, it will be important to clarify for politicians, health professionals and others, the contribution of health promotion activities to health. Programmes of health promotion should be evaluated to demonstrate their advantages to different groups. Unless it is shown to be "value for money", health promotion could fail to attract adequate funding from official sources, although the interest shown in it by the general public has suffered no such constraints. Finally it was suggested that a "European health tour", based on a cycle race linked to "health events" in several countries, would generate a large amount of publicity and media coverage for a relatively low cost. It would create interest in health promotion and foster community involvement in the linked "health events". Family activities like walking, swimming or skiing were suggested as alternative foci for health tours in other countries. There were reservations however, about the difficulties of arranging such an event, and the desirability of linking health promotion with competitive sport.

Recommendations

1. The vocabulary of "health promotion" and terms such as "positive health" are not familiar to many Member States, though the underlying concepts are. There should be further investigation of the meaning and appropriateness of this terminology for Member States - taking into account that while people move ahead in health promotion, governments hang behind.

2. The identification of priorities in health promotion depends on the availability of knowledge about what influences health. Scientific research into the "epidemiology of health" is grossly underdeveloped; progress in this field should be accelerated and the findings disseminated in a form useful to those who want to develop their own or their community's health.

3. To assess the "state of the art" in health promotion, and to facilitate the exchange of experiences, a network of contacts and collaborating centres should be established in Member States. Existing health education offices may act in the first place as resource centres. In each Member State, a mini-survey of health promotion activities should be carried out.

4. Health promotion projects should be evaluated in a scientific way, taking into account the goals of the people involved in each project. This will require the development of an acceptable and operational definition of "positive health", together with appropriate methods of measurement. The results of evaluation studies should be made widely available to assist in the planning of projects in health promotion. Projects should consider the importance of the catalyst role of countries rather than take on leadership.

5. The actual and potential contribution of different professional groups should be carefully assessed. It should not be assumed that the medical profession has a major or dominant role to play. The implications of these assessments for the training and organization of different professional groups should be specified.

6. There are dangers for health promotion of domination by a single group of experts, dictating appropriate or healthy behaviour and living conditions. The ethical pitfalls of such an approach should be debated and defined. The polarization of attention between individuals and their environments is similarly unhelpful. Health promotion is relevant to diverse interest groups and policy areas; the promotion of health should be carefully integrated into more general social development.

7. The Regional Office for Europe can make an important contribution to the development of health promotion in the following ways.

(a) It should publish and disseminate widely the consultant's study of "Health promotion in Europe", and various abstracts of the study for newspapers, journals and magazines.

(b) It should prepare for the implementation of the new MTP in Health Promotion, whose targets and approaches were enthusiastically welcomed. In particular, the Office should begin the development of a network of national counterparts and collaborating centres. A series of reports on the links between lifestyle/environment and health were urgently needed. The series could be piloted with a guide to the "Built Environment and Health".

(c) Before embarking upon the European health tour project, further consultation with people who are experienced in promoting such events was necessary.

(d) Communication and dissemination of the health promotion approach would be supported by further reports of activities, particularly of projects which illustrated elements of the approach; the presentation of "information days" on which opinion leaders, ministers and officials from several countries would come together for discussion and exchange of experiences in health promotion; preparation of a standard outline of principles and practice in health promotion in a form which could be taken or sent to Member States - slides, video, and cartoons; an international congress or symposium on health promotion.

(e) The shortage of staff for the development of the health promotion programme could be eased if the European Office offered positions to qualified young people in Member States to undertake research and programme development work. This could be on the basis of secondment for a period of six months, with about half of this time spent in Copenhagen or on visits to Member States.

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